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THE MONTANA STATE PLAN FOR COMPREHENSIVE MENTAL HEALTH SERVICES

July 15, 1979

Plan Period

July 1, 1976 through June 30, 1981

Prepared by:

Montana Department of Institutions

Cover:

"MONTANA TRAVEL PROMOTION PHOTO"

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STATE PLAN FOR

COMPREHENSIVE MENTAL HEALTH SERVICES

GENERAL INFORMATION

DEPARTMENT OF INSTITUTIONS
(Designated State Mental Health Agency)

Lawrence M. Zanto
(Director)

Hon. Thomas L. Judge
(State Chief Executive Officer)

Public Review Period June 1, 1979 to July 1, 1979

Certification for Approval
(Hon. Thomas L. Judge - Governor)

Public information concerning
this plan and public comment on
plan contents should be addressed to:

MENTAL HEALTH AND RESIDENTIAL SERVICES DIVISION
1539 11th Avenue
Helena, Montana 59601

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1

INTRODUCTION

I. INTRODUCTION

PURPOSE OF THE PLAN

The Montana State Plan for Comprehensive Mental Health Services has three overall purposes:

- To assure the State's commitment to fulfill its obligations of participation in the Public Health Services Act.
- To provide a mechanism for direction, communication and coordination between the Montana Department of Institutions and other state and local organizations involved in delivery of mental health services.
- Public accountability for the expenditure of federal, state and local tax funds in the provision of mental health services.

With these broad purposes in mind, the Department of Institutions views the state five-year plan as only one part of a continuing process of planning, review and evaluation and as such, it will be referred to extensively to assess goal achievement. Specifically, the purpose of the plan from both Federal and State perspectives is as follows:

Federal

In order for any state to meet requirements for mental health funds under Section 314(d) of the Public Health Services Act, or for any mental health project to receive funds under parts A, B or C of the Community Mental Health Centers Act, a state must have a federally approved state plan for comprehensive mental health services.

The National Institute of Mental Health requires states to describe overall goals and objectives for delivery of mental health services. At a minimum, the Plan must describe how each of the following objectives will be achieved.

- Implementation of a pre-admission screening system to eliminate inappropriate placement in institutions.
- Development of appropriate alternatives to hospitalization.
- Provision of quality care for persons with mental health problems residing in institutions.
- Provision of follow-up care for residents who have been discharged from mental health facilities.
- Implementation of statewide standards of maintenance and operation of mental health services facilities and programs.
- Implementation of methods to coordinate statewide human services programs to provide an optimum level of efficiency and effectiveness in service planning and delivery.

In addition, the Plan must describe present catchment areas throughout the State for regional delivery of services. Descriptions must include an inventory of existing facilities and services, results of a survey indicating needs for additional services, and established priorities for each regional area. Finally, the Plan must describe the overall organization structure and methods for administration of the State Plan.

State

From the State perspective, this Plan is considered a timely vehicle to bring together views of State and local government organizations, private practitioners and citizen representatives for delivery of effective and efficient mental health services. This is especially necessary in Montana where the large majority of direct service delivery occurs within five geographic regions administered by five regional mental health boards.

In the Plan development process, a fresh look was taken at present status of the Montana mental health program. As a result, it was determined that Montana is short of achieving Federal and State goals. Improvements are required in the provision of uniform and accessible services across the state, and most important in provision of service alternatives to institutionalization. With this background the plan is intended to provide a framework for:

- Public communication of state goals, policy and strategies for improved delivery of mental health services;
- Coordination of services among several state and local agencies; and,
- Evaluation of accomplishments from year to year.

Being a plan, its focus is on desired outcomes or objectives over the next five years. Achievement of objectives will require a commitment to cooperation by those state and local organizations responsible to improve and broaden needed mental health services.

OVERVIEW OF PLAN CONTENTS

The State of Montana Mental Health Services Plan presents to the citizens of Montana a detailed description of mental health services and functions presently provided and those to be provided over the next five years. The Plan describes State and local organizational structure and responsibilities, present goals and objectives for mental health service delivery, and mechanisms to be used for annual plan review and revision. In addition, an appendix is provided to present revised standards for operation of mental health programs and steps taken to assess each mental health region regarding needs and priorities of service. The overall purpose of the plan is presented in Section I.

Section II of this plan describes how the mental health program is administered. The primary purpose of this section is to describe organizational relationships within the Department of Institutions and the Department's relation to Regional Mental Health Boards and other mental health agencies. In addition, Section II outlines steps to be taken for program evaluation, reporting and annual review of the Plan. Finally, this section describes State policy for non-discrimination, personnel standards, conflict of interest and use of funds under Section 227 of the Public Health Services Act for administration of the State Plan.

Overall state goals and objectives are discussed in Section III. Summarized in this section are the results of statewide need and resource surveys to assess priorities for additional services throughout the state. Input during the assessment phase was received from

the State Advisory Council, public hearings and community mental health center regional boards. This input, along with State agency assessment of Federal and State agency requirements, formed the base for establishing specific program objectives and implementation procedures. Section III also discusses estimated manpower requirements for State agency programs and steps to be taken to determine manpower requirements for community mental health programs. Finally, this section describes the nature and extent of State agency coordination efforts with other State and local organizations.

Section IV presents detailed descriptions of the five regional mental health areas including an inventory of existing facilities, results of the need survey and description of services currently offered and those not offered. In addition, this section presents Montana Program standards for maintenance and operation of mental health facilities.

Section V lists attachments alluded to in the main body of the plan.

II

ADMINISTRATION OF THE MONTANA MENTAL HEALTH PROGRAM

II. ADMINISTRATION OF THE MONTANA MENTAL HEALTH PROGRAM

SINGLE STATE AGENCY

On April 13, 1976, Governor Thomas L. Judge designated the Department of Institutions as the single State Authority for the administration and supervision of the Montana Mental Health Program. (see Exhibit 1). In this capacity, the Department of Institutions maintains the authority and responsibility for preparation of the State Mental Health Services Plan as well as the ongoing monitoring of achievement of program objectives. Further, this department is accountable to the Federal Government for correct expenditures of Federal funds received for Mental Health Administration and program operations under Section 314(d) of the Public Health Services Act and for expenditures under Section 227 part c of the Act.

STATE AGENCY ORGANIZATION

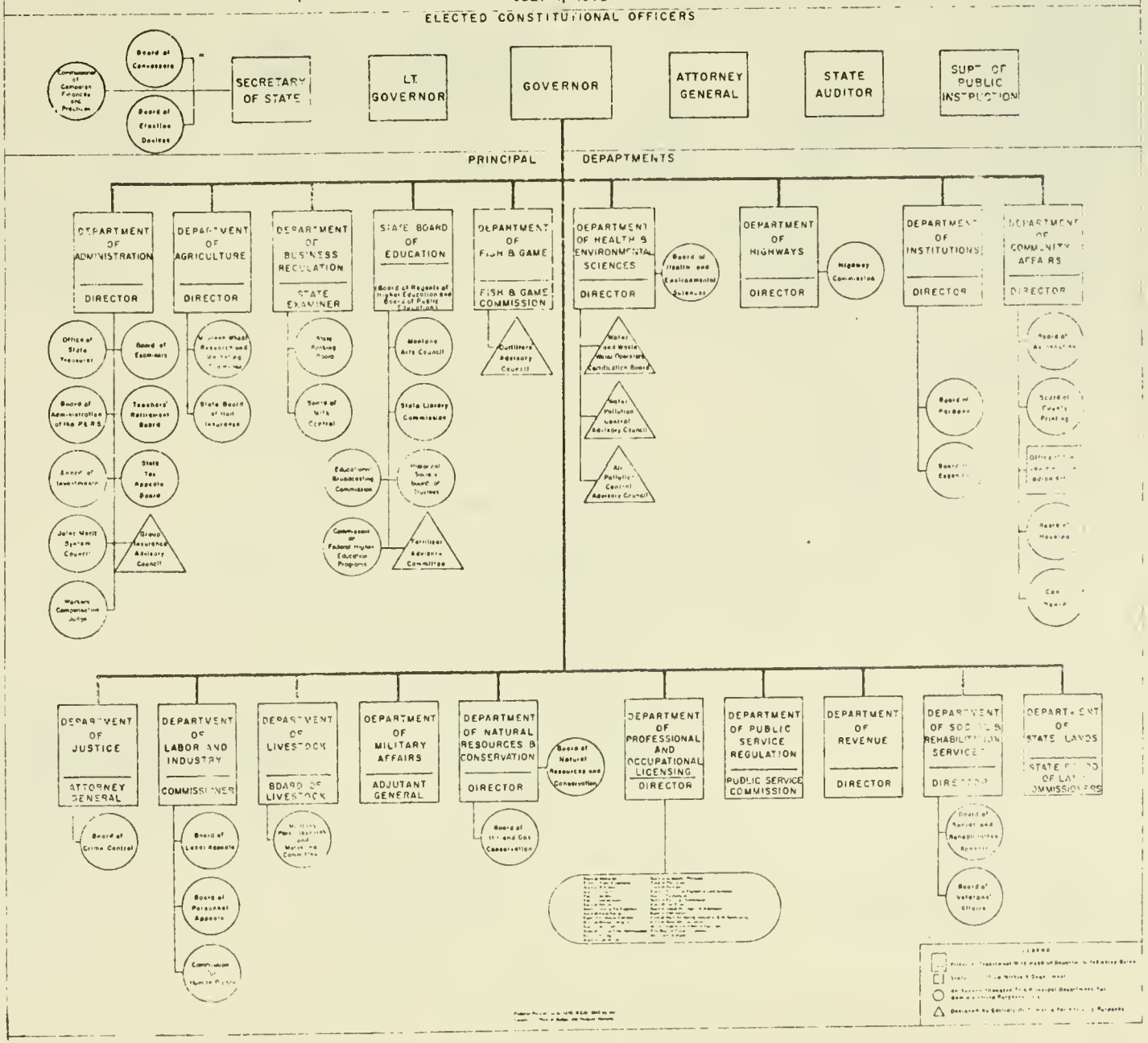
Exhibits 1, 2 and 3 present the organization structure for the overall Montana State government, The Department of Institutions and the Division of Mental Health and Residential Services. As indicated, the Mental Health and Residential Services Division is administratively responsible for provision of community based mental health services, institutionally based services for the mentally ill at Warm Springs State Hospital, institutional services for geriatrics at the Center for the Aged; services to Montana's veterans at the Veteran's Home; institutional services for developmentally disabled at Boulder River School and Hospital and Eastmont Training Center; and institutional services for alcoholics and individuals with respiratory diseases at Galen State Hospital.

Exhibit 1

STATE OF MONTANA

ORGANIZATION OF THE EXECUTIVE BRANCH

JULY 1, 1975



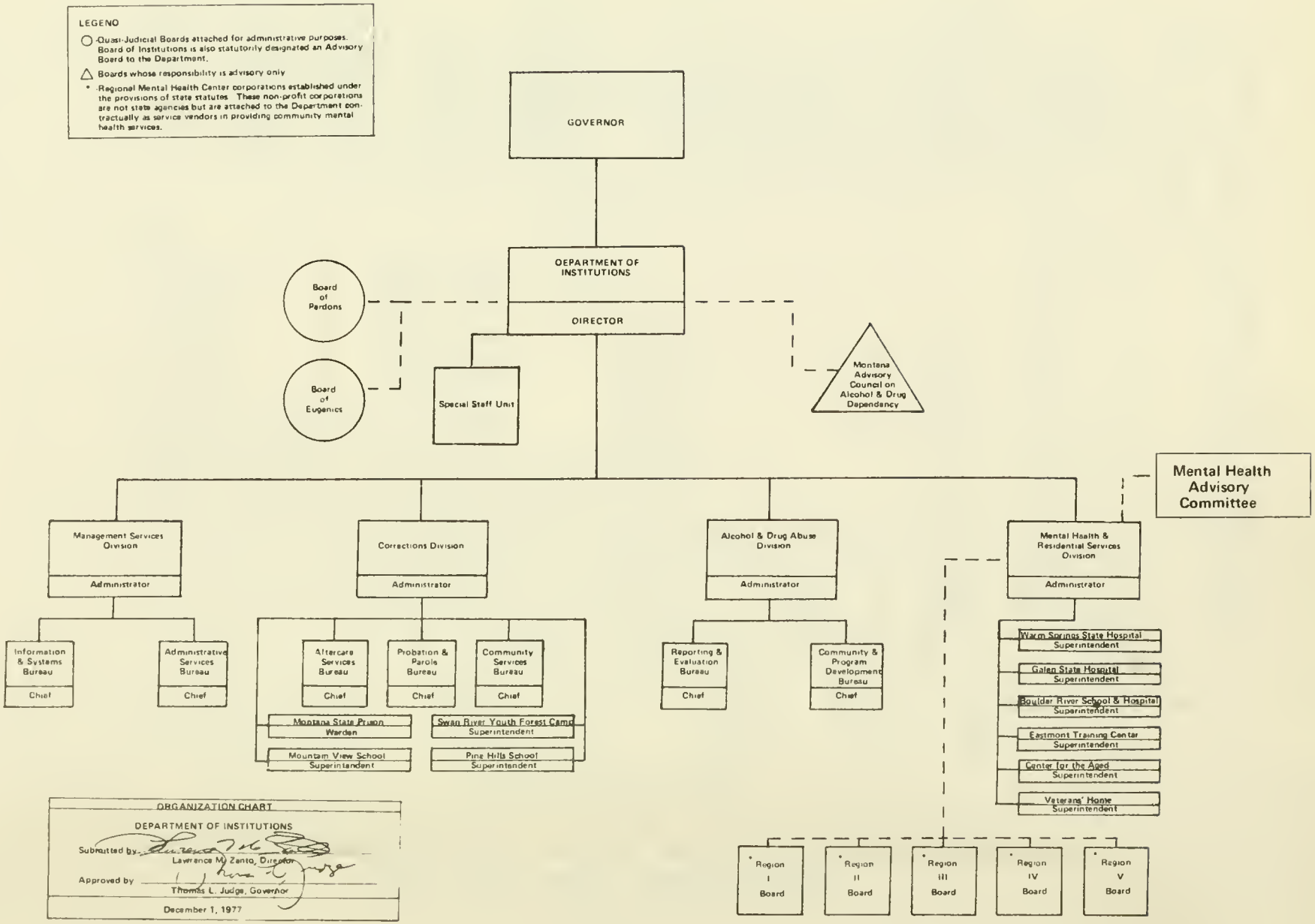
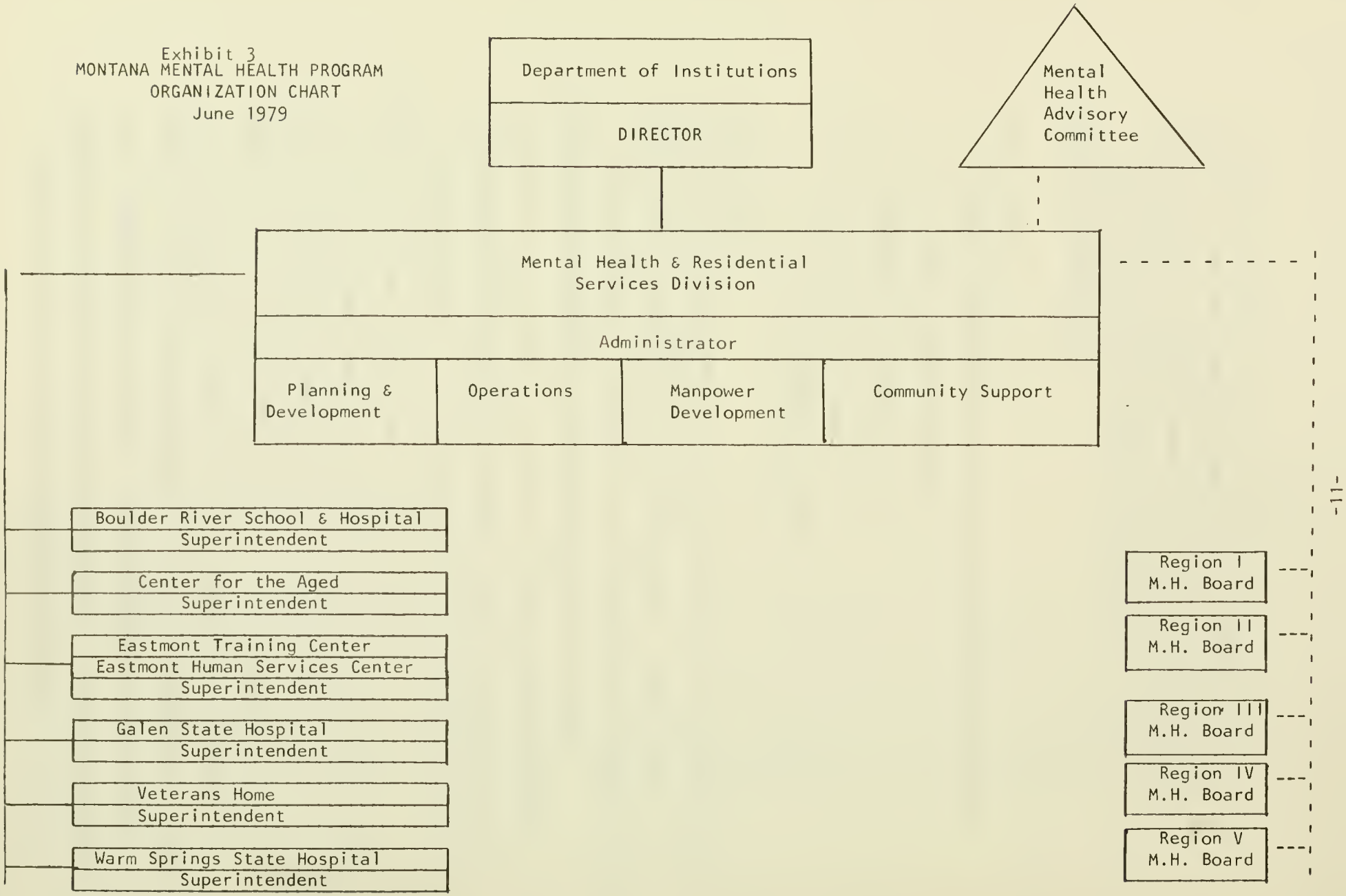

LEGEND
○ -Quasi-Judicial Boards attached for administrative purposes. Board of Institutions is also statutorily designated an Advisory Board to the Department.
△ Boards whose responsibility is advisory only
* -Regional Mental Health Center corporations established under the provisions of state statutes. These non-profit corporations are not state agencies but are attached to the Department contractually as service vendors in providing community mental health services.
GOVERNOR
DEPARTMENT OF INSTITUTIONS
DIRECTOR
Board of Pardons
Board of Eugenics
Special Staff Unit
Montana Advisory Council on Alcohol & Drug Dependency
Mental Health Advisory Committee
Management Services Division
Administrator
Information & Systems Bureau
Chief
Administrative Services Bureau
Chief
Corrections Division
Administrator
Aftercare Services Bureau
Chief
Probation & Parole Bureau
Chief
Community Services Bureau
Chief
Montana State Prison
Warden
Swan River Youth Forest Camp
Superintendent
Mountain View School
Superintendent
Pine Hills School
Superintendent
Alcohol & Drug Abuse Division
Administrator
Reporting & Evaluation Bureau
Chief
Community & Program Development Bureau
Chief
Mental Health & Residential Services Division
Administrator
Warm Springs State Hospital
Superintendent
Galen State Hospital
Superintendent
Boulder River School & Hospital
Superintendent
Eastmont Training Center
Superintendent
Center for the Aged
Superintendent
Veterans' Home
Superintendent
* Region I Board
* Region II Board
* Region III Board
Region IV Board
* Region V Board
ORGANIZATION CHART
DEPARTMENT OF INSTITUTIONS
Submitted by
Lawrence M. Zanto, Director
Approved by
Thomas L. Judge, Governor
December 1, 1977

Exhibit 3
MONTANA MENTAL HEALTH PROGRAM
ORGANIZATION CHART
June 1979



Historically, while administration and supervision of the institutional programs is maintained by the Division, provision of community based programs for the mentally ill has been contracted for through the regional Community Mental Health Center Boards. Additionally, community mental health services may be provided for directly by other state agencies or indirectly through contract or cooperative agreement with other agencies of government, regional or local, private or public agencies, private professional persons or hospitals, under rules adopted by the Department as described in Section 53-21-203 MCA.

The following is a survey of functions of each organizational unit within the Montana mental health program. These functions are predicated upon current legal and regulatory requirements of the Single State Agency designation of the Department of Institutions.

The Director of the Department of Institutions has established the Mental Health and Residential Services Division whose function is to administer and supervise the following mental health related organizational units:

- Warm Springs State Hospital
- Center for the Aged
- Community Support Project
- Manpower Development Unit

In addition the Division monitors and funds community based mental health services.

Division Responsibility

Within the Division, major task responsibility relative to mental health programs is divided among staff along four functional lines - planning, operations, manpower and community support. However, in

practice, there is considerable overlap and interaction involved in implementation of centralized divisional functions. The following are the major responsibilities of the state division office.

a. Facilitate provision of community-based mental health services through coordination with five regional mental health boards. The State mental health authority is required to insure prevention of mental illness and elimination of inappropriate institutionalization (Title 53, Chapter 21, MCA) through statewide supervision of federally required services. Technical assistance and training will be provided to each regional mental health program with special emphasis on compliance with standards.

b. State Plan

In compliance with Title 53, Chapter 31, MCA, the Department of Institutions shall prepare and maintain a comprehensive mental health plan. In compliance with P.L. 95-83 this plan must be based on an assessment of needs and resources and must have an annual review and plan revisions.

c. Standards for Maintenance and Operation

The State mental health authority is required to prescribe and provide enforcement of minimum standards for maintenance and operation of mental health programs and facilities including community mental health centers (P.L. 95-83 and, Title 53, Chapter 21, MCA).

d. Evaluation

Along with development of standards, the Mental Health and Residential Services Division will implement procedures for (P.L. 95-83 and Title 53, Chapter 21, MCA):

- determination of compliance with standards including

enactment of legally enforceable penalties for non-compliance.

- performance of administrative appeals of enforcement actions.
- performance of periodic review and revision of standards at least every five years.
- publication of proposed modifications to existing standards for review and comment at least 30 days prior to adoption.
- preparation of reports to the United States National Institute of Mental Health about the nature and degree of program deficiencies. Reports will include status of enforcement action of noncompliance with established standards for projects approved under the Community Mental Health Centers Act.

e. Funding

The Mental Health and Residential Services Division shall make recommendations to the Administrator for allocation of State Funds based on assessment of mental health needs and performance of mental health programs.

Warm Springs State Hospital

The Superintendent of Warm Springs State Hospital (WSSH), will be responsible for administration of institutional care to the mentally ill. Supportive services provided at WSSH include:

- individual and group therapy consisting of one-to-one or one therapist with several patients.
- occupational therapy regarding specific work training

for purpose of restoring psychological functioning.

- recreational therapy regarding planned recreation for purpose of resolving psychological malfunctioning.
- industrial therapy regarding work activities for purpose of improving psychological functioning.
- educational counseling and training including academic and vocational-technical regarding planned educational activity to rehabilitate patient.
- music therapy: Use of music as a medium to resolve psychological malfunctioning
- complete medical and nursing care provided on a 24-hour basis.

In addition, WSSH personnel will coordinate aftercare and follow-up services for discharged patients with regional community mental health center.

Montana Center for the Aged

The Montana Center for the Aged is a residential facility for geriatric clients who have an associated mental disability, but who do not require the "intensity of care provided at Warm Springs State Hospital. Support services provided at the Center include:

- psychiatric consultation on patient treatment
- recreational therapy oriented towards the maintenance of each individual's emotional and physical health
- full medical and nursing care of a skilled, intermediate and personal care level to deal with such complications as are typically associated with a geriatric population

Community Support Program

The Community Support Project is a unit within the Mental Health and Residential Services Division to develop a statewide system of community based services for the severely mentally disordered adult. Funded for four years with federal and state monies, this unit last year developed a demonstration model in South Central Montana Mental Health Center, for expanded and increased services to the chronically mentally ill. This year the model will be further refined and utilized in Eastern Montana Mental Health Center to strengthen and intensify services to this segment of the mental health population. This system envisions a close, interaction between centers and mainstream human service agencies to improve community care for the mentally ill.

Community Mental Health Centers

As of July, 1975, local community mental health centers (CMHC) were empowered to become private non-profit corporations separate from direct State agency affiliation. Present legal authority of CMHC's is outlined in Section 53-21-201 through 53-21-206, MCA. In the same law, the Department of Institutions is empowered to contract with regional mental health corporations for the purpose of the prevention, diagnosis and treatment of mental illness. In turn, these governing boards of centers have created advisory boards to assess needs of citizens and report back to parent boards. In line with this sanction, the department has chosen to contract with five regional mental health boards for provision of a range of services that include all of the following as appropriate to the needs of individual catchment areas:

- Inpatient: provision of 24-hour short-term care and

evaluation typically provided in a medical setting.

- Outpatient: provision of group and individual therapy on a regularly scheduled basis.
- Day Treatment or Partial Hospitalization: provision of less than 24-hour care or partial hospitalization during nights, evenings, days or weekends.
- Emergency: provision of immediate mental health care and evaluation for persons in crisis on a 24-hour a day basis. Service is provided on a face-to-face and crisis telephone basis.
- Children and Elderly: provision of a full range of diagnostic, treatment, liaison and follow-up services with special attention to these two developmental stages who are frequently underserved.
- Alcohol and Drugs: Assessing needs for services to drug abusers and alcoholics and based upon these needs, insuring adequate and comprehensive services are available and accessible.
- Transitional or Halfway Houses: provision of residential treatment to individuals released from institutional care who, in the absence of such facilities, would require in-patient services. This service fosters gradual, phased return to community living.
- Follow-up and follow-along: establishment and maintenance of contact with persons discharged from in-patient care in order to insure treatment availability.
- Screening and diagnosis: provision of diagnostic evaluations for courts and other public agencies with persons who

are being considered for referral to State mental health facilities. Such screening is also performed for current institutional residents to insure appropriateness of placement.

- Consultation and Education: provision of training and assistance to a wide range of individuals involved with mental health services, including health professionals, schools, courts, state and local law enforcement, members of the clergy, public welfare agencies and other appropriate entities. In addition, provision of mental health education for all citizens of Montana. The governing boards of the mental health centers are mandated by law (section 53-21-204 MCA) to be comprised of county representatives designated by the county commissioners for a period of two years. Advisory boards, in addition, are appointed to assist the governing board and staff in assessing community needs, planning, policy making and overall representation of diverse community interests.
- Minorities: provision of comprehensive services to Indians, Chicanos and other minorities members.

GOVERNOR'S ADVISORY COUNCIL

Designation and Role

Governor Thomas L. Judge appointed the Montana Mental Health Advisory Council in July, 1974, to "conduct a thorough study of the current and probable future problems, needs and opportunities the government of the State of Montana will experience in the field of mental health in the next five years, and present its findings, conclusions and recommendations to the Legislature and the Governor, as mandated by legislative resolution: H.J.R. 66.

The Council conducted two-day meetings every other month. Records were kept of attendance and content of Council meetings. Council activities in the past have included:

- Site visits to Warm Springs State Hospital, Pine Hills School, Mountain View School, and the regional Mental Health Centers.
- A public hearing, solicitation of public testimony and public education.
- Assessment of State and other institutions regarding inappropriate placement, and deinstitutionalization.
- Analysis of State statutes and development of suggested revisions.
- Review of present and potential funding mechanisms.
- Discussions of mental health problems of children.
- Consideration of screening and evaluation procedures and services.
- Development of mental health goals and objectives.
- Comparison of Montana problems and programs with those of selected other states.
- Review of selected current prevailing literature.
- Development of liaison with State agencies; Federal, State and local advisory councils and committees;

- consumer organizations; and professional associations.
- Discussion of the roles of public schools in mental health.

Documents containing the findings, conclusions and recommendations of the Council were submitted to the Governor and Legislature in January 1975 and in January, 1977. The Council was continued to facilitate the implementation of these recommendations. In January 1979 a revised and additional set of recommendations was issued by the Council. It has not been funded for the 1980-81 biennium, thus concluding its service on June 30, 1979.

In 1977 the Council accepted an invitation from the Department of Institutions to add to Council responsibilities an advisory function for the Division of Mental Health & Residential Services in the preparation of the Montana State Plan for comprehensive mental health. The Council met with the Division staff, quarterly, for the purpose of:

- Participating in the annual review and updating of the State Plan.
- Reviewing implementation progress of the State Plan as compared with stated objectives.

The goals and objectives and standards as stated in the Comprehensive Mental Health Services State Plan were submitted to the Council on May 3, 1979. The Council has responded with detailed comments and recommendations.

Composition

The Montana Governor's Mental Health Advisory Council has thirteen (13) members, of which 60% are non-providers of mental health services, and 40% are direct or indirect service providers. As shown on Exhibit 4

on the following page, the Council members originate from each of the five regional catchment areas, and include representatives from the following classes:

1. Consumers, including clients and their families
2. Providers of mental health services
3. Non-government organizations and groups
4. State agencies.

Two members were appointed to the Council to comply with Federal requirements, a Native American and a youth represented their respective groups. The overall membership of the Council has been changed to allow for rotation and broad representation.

HEW Advisory Committee

Continuation of the Mental Health Advisory Council function in reviewing and assisting with the Mental Health Plan is assured for FY 80 and FY 81 by adequate legislation appropriation.

REPORTS

The Department of Institutions will make reports containing information as the Secretary of the Department of Health, Education and Welfare, may reasonably require. The Department will keep records and afford access thereto as the Secretary may find necessary to assure the correctness and verification of these reports.

In addition, the Department of Institutions and regional community mental health centers will retain all financial documents, and records, for two years after each contract period.

Exhibit 4

MONTANA MENTAL HEALTH ADVISORY COUNCIL

NAME	CLASS	REGION	RESIDENCY	OCCUPATION	AREAS OF INTEREST
Gary R. Marbut, Chm.	1,3	V	Missoula	Rancher/Former Legislator	Developmental Disabilities Planning & Advisory Council
Joe DeLong	1	V	Somers	Rancher/Former County Commissioner	Council for the Aging
Jane Edwards, Vice-Chm.	2,4	IV	Anaconda	Nurse	Warm Springs State Hospital
Patricia Gesek	1,3	V	Whitefish	State Representative Businesswoman	Legislature; Flathead Mental Health Advisory Board
Marilyn Greely	1	IV	Helena	Nurse	Childrens' Services
Dee Ann Gribble	1	V	Missoula	Student	Youth
William Hague, M.D.	2	III	Billings	Psychiatrist	Montana Psychiatric Association
Helen M. Huennekens	2,3	III	Billings	Mental Health Worker	South Central Montana Mental Health Assn; Mental Health Center; School Counselor
James Dorr Johnson	1,3	IV	Butte	Lawyer	Legal Services Association
Joan-Nell Macfadden	1	II	Great Falls	Housewife	Cascade County Mental Health Advisory Board
William Thomas	4	II	Great Falls	State Senator	Legislature
William Warfield	1,3	IV	Livingston	Rancher/Former Legislator	Southwest Montana Mental Health Center Governing Board
Janet Wollersheim	2,3	V	Missoula	Psychologist, Educator	Montana Psychologists Assn.

1 - Representatives of consumer, including clients and their families
2 - Provider
3 - Representatives of non-government organizations of groups
4 - Representatives of State Agencies

ANNUAL REVIEW

The Department of Institutions views the review and planning process as a continuing series of activities resulting in regular plan assessment and revision. On at least a quarterly basis, staff of the Mental Health and Residential Services Division will review progress in achieving plan management objectives and prepare a progress report to be distributed to Department Management, the State Mental Health Advisory Committee, WSSH, regional office of N.I.M.H. and Regional Mental Health Center Boards. The State Mental Health Advisory Committee will participate in this review. As part of the report, revised objectives or due dates for completion may be necessary depending on identified constraints to achieving expected results. As noted in Section III of this plan, objectives are a combination of expected program changes such as shifts of populations from institutional to community based programs, and administrative changes resulting in increased state agency capacity to monitor programs operations. However, achievement of both types of objectives will be monitored to report statewide accomplishments. On at least an annual basis, a summary of these reports along with the following year's revised program objectives will be made public by distribution to the mental health Advisory Committee and Regional Mental Health Boards. Further, notification will be placed in all major state newspapers notifying the public of the location of the mental health plan. Results of public comment and annual plan revisions will be submitted to NIMH on an annual basis.

Program Compliance

The Department of Institutions has established an organizational plan within the Mental Health and Residential Services Division to conduct annual site visits to evaluate mental health program compliance.

with State and Federal standards. Results of evaluations identify areas for the technical assistance and eventually become the basis for program accreditation. The evaluation process does focus on at least four functional areas as outlined below:

- organization - includes the role of the Board of Directors and Community Advisory Committees, coordination with other human service agencies, procedures used for self-evaluation and use of policy and procedure manuals for staff direction.
- fiscal - includes budgeting, billing process, and overall control of revenues and expenditures.
- client treatment - includes case record documentation, systems for pre-admission screening and followup on discharged clients, suitability of facilities, hours of operation, and verification of statistical reports described above.
- personnel - includes policies and procedures, staff performance evaluation and training programs.

This evaluation process includes submission of a written report of findings to Regional Boards and program management, which outlines strengths, weaknesses and recommendations for corrective action. A formalized response outlining proposed action steps to correct deficiencies and milestones for completion are required from program management.

PERSONNEL ADMINISTRATION

Personnel Standards

Methods of personnel administration have been established and will be maintained in the State agency in conformity with the Standards for a Merit System of Personnel Administration, 5 CFR, Part 900,

Sub-part F, and any standards prescribed by the U.S. Office of Personnel Management pursuant to the Reorganization Plan Number 2 of 1978. Citations of applicable State laws, rules, regulations and policies which provide assurance of conformity to Federal Merit System Standards and to any standards issued by the U.S. Office of Personnel Management are attached for review and determination of adequacy (Attachment 2). Amendments to this list of citations will be submitted as necessary.

Nondiscrimination

The State agency, and Community Mental Health Centers comply with non-discrimination policies for services and employment as stated in Title VI of the Civil Rights Act of 1964 (42 USC 2000D; 78 Stat. 252), the 1972 Montana Constitution, and Title 49 of the M.C.A. (See attachment 3).

Affirmative Action Plan

The State agency has developed an affirmative action plan to assure equal opportunity in all aspects of personnel administration as specified in 45 CFR 70.4. The plan provides for specific action steps and timetables to ensure equal opportunity. The plan is available for review upon request and has been reviewed and approved by H.E.W. regional office.

Conflict of Interest

In compliance with Montana Law, 59-501 R.C.M. 1947, no full-time officer or employee of the State Agency, or any firm, organization,

corporation, or partnership which such officer or employee owns, controls or directs shall receive funds from any applicant directly or indirectly for payment for services provided in connection with the planning, design, construction, equipping or operation of any projects funded under the Community Mental Health Centers Act.

STATE PLAN ADMINISTRATION FUNDS

The single state agency for administration and supervision of Mental Health Programs including construction of community mental health facilities is the Department of Institutions (see Attachment 1). Methods for administration of federal funds under section 314(d) of the Public Health Services Act (the Act) and section 227 part C for facilities assistance are as follows:

Section 314(d)

Presently the Department of Institutions is allocated 15% of federal funds received under Section 314(d) of the Act. The remaining 85% is administered by the Montana Department of Health and Environmental Sciences for statewide health services. The mental health portion for FY '79 is #83,200.00. These funds have been distributed as follows:

Central Mental Health Administration - (30%) $24,960.00.
Utilized to pay 6% of operational costs of Mental Health & Residential Services Division's budget.

Regional Mental Health Boards - (70%) $58,240.00.
Utilized as follows:

a) Region I award = $6,000.00 for series of Parent Effectiveness Training workshops.

b) Region II award = $28,867.00 for start up costs for transitional care facility,

c) Region V award = $23,373.00 for operational costs for transitional care facility in Kalispell

Methods used for allocation and administration of funds to regions are:

- Regional Mental Health Boards are notified about availability and amounts of 314(d) funds.
- each Regional Board submits a proposal for use of funds to the Mental Health & Residential Services Division for Division and Department management review.

- Based on results of review, funds are allocated among regions.

- Contracts are written with each region to specify state and federal expenditure and program requirements.

- Monitoring of contracts is performed by the Division on an annual basis, including on-site visits along with Federal NIMH staff.

227 Part C - Facilities Assistance Funds

Should federal funds for mental health facilities assistance become available for fiscal year 1980, the Department will request 5% of those funds to assist in administration of the State Plan. The first application for funds will show the amount requested for administration and a categorized listing and explanation of federal and state funds to be used for administration of facilities development projects. Further, not later than 60 days after the end of each fiscal year during which these funds have been expended, the Administrator of the Mental Health and Residential Services Division shall certify that federal funds for administration of facilities project development have been utilized in accordance with the Act. A statement of actual expenditures by source and type will be included.

Methods used to distribute funds will be:

- Regional Mental Health Boards will be notified about availability of facilities assistance funds under Section 227 part C of the Act.

- Application for use of funds will be reviewed by the Mental Health and Residential Services Division and Department of Institutions management along with the Mental Health Advisory Committee. A factor for approval of applications will be consistency with overall goals and objectives of the Montana Mental Health Services Plan.

- Applications recommended for approval will be reviewed and approved by the Health Systems Agency of Montana.

III

MONTANA COMPREHENSIVE MENTAL HEALTH PROGRAM

PRESENT STATUS

This section of the Plan is a general overview of the evolving Montana Mental Health Program. Over the past several years there has been an increase in community-based mental health services. Programs have changed from the mental hygiene clinic concept with services located only in major cities to a regional mental health center concept with mental health services offered in the majority of counties in the State.

The Centers are progressing toward services to a much wider array of disordered persons on a local basis. However, the change is not complete. Further improvements are required to insure uniform and accessible mental health services statewide. Services are not uniform due to differences in regional funding, population, and staffing patterns. Services are not as accessible as they might be as several counties are not financially participating in mental health programs. In addition, several required services such as day treatment, children's services and transitional care are provided in only a few of the larger counties.

Another significant change in Montana mental health services is the purpose of the State Mental Hospital.

1) The current trend in the institution is away from custodial and toward therapeutic patient care.

2) The concept of milieu therapy, with early return of patients to the community whenever possible, is the essence of modern therapeutic patient care.

3) By means of individualized patient treatment plans and frequent and regular utilization review, the hospital is improving patient care and treatment.

4) Improvements are also now being made in preadmission screening to alleviate inappropriate placement of persons with mental illness; and in diagnostic evaluation to relocate persons into less restrictive alternatives as appropriate.

Overall, Montana is progressing in developing a responsive mental health program. However, as summarized below, during the next five years a significant amount of work is yet to be accomplished.

Funding of Mental Health Centers:

The community mental health centers are funded from federal, state and local sources. Actual expenditures for state, FY '78, and estimated expenditures for state, FY '79 are shown in the following chart:

COMMUNITY MENTAL HEALTH CENTER FUNDING BY REGION

Actual 78

	Region I	Region II	Region III	Region IV	Region V	Total
Federal	$229,028	631,815	397,920	237,183	168,421	$1,664,367
County	45,109	93,822	103,112	51,425	29,152	322,620
Program Income & Reserves	224,527	265,777	632,268	321,099	104,445	1,548,116
State	369,318	368,458	449,885	465,806	472,023	2,125,490
Total	867,982	1,359,872	1,583,185	1,075,513	774,041	5,660,593

COMMUNITY MENTAL HEALTH CENTER FUNDING BY REGION

Budget 79

	Region I	Region II	Region III	Region IV	Region V	Total
Federal	$177,769	631,816	497,761	218,969	120,421	$1,646,726
County	45,097	99,450	107,530	52,453	48,898	353,428
Program Income & Reserves	278,942	468,585	472,710	388,883	248,493	1,857,613
State	575,284	578,219	657,773	587,517	575,838	2,974,631
Total	1,077,032	1,778,070	1,735,774	1,247,823	933,650	6,832,399

The following summary describes in more detail present status of each service component of the Montana Mental Health Program. The summary includes:

1. pre-admission screening;
2. alternatives to hospitalization;
3. follow-up care;
4. Warm Springs State Hospital.

Pre-Admission Screening

To eliminate inappropriate placement of persons in the Warm Springs State Hospital, the Forty-Fourth Legislature of the State of Montana passed extensive legislation effective July 1, 1975 with revisions in 1977 and 1979 to provide for determination and treatment of the seriously mentally ill. This legislation parallels Federal Public Law 94-63 as it addresses the elimination of inappropriate placement in institutions of persons with mental health problems.

As defined in Section 53-21-102(14) M.C.A., "seriously mentally ill" means suffering from a mental disorder which has resulted in self-inflicted injury or injury to others, or to the imminent threat thereof; or which has deprived the person afflicted of the ability to protect his life or health. No person may be involuntarily committed to a mental health facility nor detained for evaluation or treatment because he is an epileptic, mentally deficient, mentally retarded, senile or suffering from a mental disorder unless the condition causes the person to be seriously mentally ill within the meaning of the Act."

An effective screening program should have at least two major foci; community education and liaison, the regional mental health centers should notify courts and other relevent public agencies of the availability of the screening service and the design of legislation pertaining to commitment.

The patient evaluation process should be available to any appropriately identified person in the community who is being considered for institutionalization and should be based on the most comprehensive assessment practicable, including but not limited to psychiatric assessment, psychological evaluation and social history data.

Pre-admission screening is the mechanism by which a person is appropriately placed in the State Hospital or referred to a community based treatment program. Community mental health centers are required to provide assistance to the courts and other public agencies in screening catchment area residents who are being considered for referral to the State Hospital in order to determine the appropriateness of such referral. Screening is also designed to identify persons for whom treatment through the center is an appropriate alternative to institutional care. Because it is apparent in Title 53, Chapter 21, M.C.A. the courts should utilize the community mental health centers for screening persons prior to commitment to Warm Springs State Hospital, a meeting was held in June, 1975 for persons who would be directly involved with the commitment process. Specifically, the focus of the meeting was to inform judges, lawyers, and mental health personnel of appropriate entry procedures into Warm Springs State Hospital. While these early efforts began the implementation of Title 53, Chapter 21, M.C.A., additional work was affected in consultation and education of judges and attorneys. In July 1977, some changes were made in the commitment bill to simplify this procedure. At present, courts continue to by-pass mental health centers and commit persons to the State Hospital for 60-day court evaluation commitments via the criminal code. Courts frequently send persons directly to the State Hospital for preliminary evaluations, even though the intent is clear that a community professional person should perform an initial interview in order to determine if an inpatient evaluation

and treatment is warranted.

Exhibit 5 presents the most recent admission and discharge statistics at Warm Springs State Hospital for calendar years 1977 and 1978.

In addition to the above mentioned problem area, Warm Springs State Hospital, faced with an inconsistent admission policy, developed a formal admission policy in January, 1979 which strongly advocated preadmission screening by the community mental health centers and/or private practitioners. However, referrals are still being made to Warm Springs State Hospital without preadmission screening. Accordingly, a workshop for judges and county attorneys is planned for October, 1979.

There was only one formal, regional screening unit in the state. The unit was located in Region V, Missoula and opened in late February, 1976. It was a pilot project funded by 314(d) monies. (Grants to states for public health services - Section 314(d) Public Health Services Act, July 1, 1968 as amended.) The project included a screening team consisting of a psychiatric social worker who was director, a psychologist whose function was training, part-time help from the staff psychiatrist, and senior and graduate students from the University of Montana who were enrolled in psychology and social welfare.

In calendar year 1977, 88 evaluations were completed. Although the demonstration phase was completed in July 1978, the Western Regional Mental Health Center continues to provide this service through its present staff.

In February 1978, the Community Support Project entered its 2nd year within the Department of Institutions. The goal of this project is to a) further develop and implement, with the assistance of the South Central Montana Mental Health Center, Mental Health Association and Warm Springs State Hospital, a local demonstration model to expand and improve current services to the adult mentally ill, fill existing gaps and develop new

Exhibit 5

WARM SPRINGS STATE HOSPITAL ADMISSION-DISCHARGE STATISTICS

Calendar Years 1977 nd 1978

ADMISSIONS	REGIONS I		II		III		IV		V		TOTAL	
	77	78	77	78	77	78	77	78	77	78	77	78
Types:												
First Admissions	19	20	40	37	31	40	104	113	62	59	256	269
Re-Admissions	24	26	38	30	39	31	124	132	70	48	295	267
Others	44	60	143	101	76	76	247	260	234	189	744	686
Placement Returns	0	1	0	2	1	0	5	8	0	0	6	11
Kinds:												
Court Order	30	12	83	36	41	31	95	67	57	96	406	242
Court Order Eval.	4	4	21	12	15	17	38	29	23	23	101	85
Emergency	0	4	1	0	1	0	3	12	1	2	6	18
Transfer	0	1	0	1	0	0	0	0	0	1	0	3
Voluntary	41	57	89	80	69	64	330	336	155	126	684	663
Involuntary	16	29	48	41	36	35	52	69	53	48	205	222
TOTAL ADMISSIONS	87	107	221	170	147	147	480	513	366	296	1301	1233
DISCHARGES												
Discharges	36	44	70	58	62	51	201	211	121	85	490	449
Home Visit-CVL-AWOL	43	51	138	85	68	68	237	243	225	185	711	632
Home Visit Placement	10	2	14	7	27	4	23	9	9	8	83	30
Death	3	1	0	3	3	2	5	7	3	4	14	17
Transfer	10	22	20	34	20	23	42	65	22	38	114	182
TOTAL RELEASES	102	120	242	187	180	148	508	535	380	320	1412	1310
IN HOSPITAL CENSUS As of 12-31-78	58	45	65	48	64	63	84	125	92	68	363	349

Source: Daily W.S.S.H. Admission and Discharge Sheets

programs as needed in the community, b) Utilize this model in expanding program development throughout the rest of the state in meeting the needs of the chronically mentally ill. Two statewide workshops are planned this year bringing together judges, county attorneys and mental health clinicians to look at referrals made by the courts to mental health agencies and the services provided therein.

In summary:

- Courts seem reluctant to use mental health centers for pre-admission screening.
- There is a need for more extensive screening procedures in all of the five regions.

Alternatives to Hospitalization

Ideally, it is the Regional Mental Health Center's function to insure the availability and continuity of services for all persons with mental health problems and to mitigate hospitalization. It is currently within the realm of the center's capability to provide the original five (5) essential elements of service; inpatient, outpatient, emergency, partial hospitalization and/or day care, and consultation and education.

In addition to the five (5) original services, seven more service elements have been mandated by PL 94-63, Section 201 (A-H). To reiterate, they are: children's services, services for the elderly, screening, follow-up care, transitional halfway houses, services for the treatment and prevention of alcoholism, and treatment and prevention of drug addiction and abuse.

In considering alternatives to hospitalization, the following narrative will summarize the status in Montana of both treatment and domiciliary programs for persons with mental health problems.

Treatment

Inpatient Services

This service is designed to provide a therapeutic environment for persons with severe emotional problems who require 24-hour care. The thrust of inpatient care is to provide short-term, intensive treatment and/or evaluation in a humane manner which promotes and preserves the dignity of the patient. The focus of community mental health center inpatient units is active treatment, short stay, and carefully planned referral to the community with followup care and/or referral to the State Hospital if longer-term treatment is required. In general, inpatient service is utilized only when, and for so long as, other center services are not appropriate.

Overall three of the centers (Northcentral, South Central and Western) have affiliating agreements with local hospitals containing psychiatric units; the other two centers admit patients to local hospitals without psychiatric units. Overall, inpatient services are available in Montana.

Because of Montana's shortage of psychiatrists this service is sometimes hampered by temporary shortages in the psychiatric area.

Outpatient Services

This is the most widely used service in the regional mental health centers. It provides the necessary therapies for clients who can be maintained on this basis. Outpatient services are usually provided on a regularly scheduled basis. Clients are seen for non-scheduled visits during times of increased stress or crisis. Thirty-four offices are available on a full time basis throughout the state. Where resident satellite offices are not available, traveling staff members from neighboring counties visit once or twice a week.

Emergency Service

This service provides immediate health care and evaluation for persons in crisis on a 24-hour-a-day, seven-day-a-week basis. The regional mental health centers have a mental health professional on call for either consultation or direct service, as needed.

The more populated communities have crisis telephone service manned by trained workers and/or staff members of the mental health center. A list of mental health professionals who are on call are available to the workers on the crisis telephone.

Also, it is not unusual for local hospitals or law enforcement agencies to call community mental health center professionals for emergency service. Most often, those individuals receiving emergency care are transferred to other services of the center, as their needs dictate.

Because of Montana's rural nature, emergency services are somewhat inadequate. This is due, in part, to the large geographical areas made up of several small cities and towns, with crisis telephone services located only in major cities. Persons residing in small cities and towns often are reluctant to call long distance for this service although some do use the service. However, professionals for the most part, located in the satellites are on call, but are not always available, to provide consultation and direct service for persons in a crisis situation. The Mental Health Center Advisory Boards should have a role in publicizing and supporting this service.

Day Treatment and Other Partial Hospitalization Services

The five Regional Mental Health Centers are currently providing day treatment services for persons with acute and long term mental

health problems. Persons in day treatment may have been discharged from Warm Springs State Hospital, private hospitals, or referred by other services of the mental health centers or other community agencies.

Day treatment service is designed to provide a therapeutic program for those persons who require less than 24-hour a day care, but more than out-patient care. This service has proven to be an effective transition between full-time care and return to the community in Montana.

There are thirteen day treatment facilities available in Montana with services offered from 20-40 hours per week and open 3-5 days per week.

Although partial hospitalization can be effectively tailored to meet a range of patient needs and reduce hospitalization, manpower and funds have limited this program. To date, night care and weekend care facilities are not available. There are centers which provide group therapy during evening hours to meet the needs of special categories of clients.

Consultation and Education

This service is provided across the State. The Regional Mental Health Centers are providing some consultation and education (C & E) to schools, courts, law enforcement agencies, and health services delivery agencies. The Montana Association for Mental Health does address the general public on the nature of mental health problems and types of services available but suffers from insufficient chapter development to cover all parts of Montana.

The Mental Health Association of Montana is a volunteer organization concerned with improving the mental health of citizens of Montana. The Association is part of a three-level structure which is composed of the

National Association for Mental Health (headquarters in Arlington, Virginia), State Associations and local chapters. The state association is located in Helena. There are currently 12 local chapters of the Association in Montana: Anaconda, Blaine County, Cascade County, Daniels County, Gallatin County, Helena, Miles City, Molt, Pondera County, Sheridan County, Silver Bow County and Yellowstone County.

The Mental Health Association of Montana is governed by a 24-member Board of Directors. The Board is composed of citizens representing the five mental health regions. The staff consists of one secretary.

The mission of the Mental Health Association via research, social action and education is:

1) Prevention of mental illness;
2) Promotion of mental health; and
3) Services for those in need.

As can be expected, Montana's Mental Health Program is currently undergoing revision to implement additional services. As described below, some regions have progressed further than others.

Specialized Services for Children

In addition to the Children's Unit at Warm Springs State Hospital, children have always received care at Regional Mental Health Centers. However, due to the specific nature of their needs and specialized training needed to provide services, greater attention should be paid to programs for children.

There are special programs for children with emotional problems that have been federally funded in two of the five regions. Region III has a children's grant to provide consultation and education to schools, day care services for children, and group therapy for parents. Outpatient services for children are available in all five Mental Health Center Central

offices and 28 satellites and workers skilled and experienced in children's work are employed. The centers do have children's specialists who are assigned responsibility for managing the children's programs.

A full range of programs are needed to include children who are: abused and/or neglected; psychotic, acting out; or are suffering from emotional disturbances or organic disorders.

There is one private residential home for children with emotional problems in the State located in Billings. A special unit has been developed for children's treatment at Warm Springs State Hospital. The development of an intensive care home for 10-12 emotionally disturbed children is envisioned for Great Falls during FY 80.

The Community Mental Health Centers Act of 1975 stresses that a Regional Mental Health Center must devote a meaningful portion of their resources to addressing the needs of children. Services for children should include the full range of services made available by the center, appropriately geared to the needs of children at different stages of development. There is need for extensive coordination and collaboration with children's agencies and services throughout the state.

Specialized Services to Elderly

Programs for the elderly should address the full range of diagnostic treatment, liaison, and followup services. Since for many elderly, opportunities for social contact are restricted, it is particularly important that followup services be carefully planned and implemented with the aim of maintaining therapeutic gains and reducing the impact of isolation. As many elderly citizens have little knowledge and awareness of mental health problems and very seldom voluntarily seek out

services, an extensive mental health education thrust is necessary to really involve this segment.

Many elderly patients are being deinstitutionalized. The Regional Mental Health Centers are responsible for their placement and treatment. This service has been funded in the past from a contract between the Department of Institutions and the Regional Mental Health Centers. There are few formalized programs specifically for the elderly other than placing inappropriately housed patients from Warm Springs State Hospital into nursing homes, but most centers do provide transportation, include patients in day treatment and consult with nursing homes. There is a beginning attempt to assign specific responsibilities to one person in the center and a plan of action drawn up.

In March, 1979 the Montana Mental Health Manpower Development Project in collaboration with the Rocky Mountain Gerontological Center at Salt Lake City, Utah presented a three day workshop on aging to interested professionals. This workshop will be conducted again in 1980 and 1981.

The Center for the Aged, owned and operated by the Department of Institutions, is a long term care facility capable of providing skilled, intermediate A and intermediate B levels of care and treatment for a resident capacity of 202 patients as prescribed by Title XVIII and Title XIX of Medicare.

An adequate staff provides an open campus, home-like environment to residents who must, by law, be referrals from the State Mental Hospital at Warm Springs or Mental Health Centers and who must also be ambulatory and over 60 years.

Alcohol Services

Regional alcohol and drug plans were developed in each of the five mental health planning regions. The Alcohol and Drug Abuse Division contracted with consultants for development of the five plans. A standardized regional planning format was utilized in all five regions so that similar areas of need could be pinpointed. Public hearings were held in the various regions to allow community input into the plans.

To date, two community mental health centers have been issued "state-approval" for delivery of alcoholism services: Southwestern Montana Mental Health and Alcohol Program in Helena (Region IV) and Southcentral Montana Mental Health Center in Billings (Region III).

The Southwestern Montana Mental Health and Alcohol Program provides alcoholism services to outlying communities in several counties throughout Region IV utilizing satellite centers.

Southcentral Montana Mental Health Center also provides alcoholism services through satellite centers in Region III. In 1978 the ADAD contracted with the Center to administer the Stillwater County Alcohol Program in Columbus.

Administrators of the Alcohol and Drug Abuse Division and the Mental Health and Residential Services Division meet frequently to insure that a coordinated effort in planning for community based service delivery is an on-going process between the Divisions' staff. An example of this coordinated effort is in the planning and conducting of on-site program reviews. Evaluation sections of both Divisions have worked out a coordinated evaluation schedule so they can jointly evaluate community agencies providing both mental health and alcohol services.

Drug Services

Drug abuse treatment and rehabilitation services are provided by:

- Southwestern Montana Drug Program
- Lighthouse Residential Treatment Center
- Rimrock Foundation Drug Program
- Four state correctional institutions

Southwestern Montana Drug Program (SMDP) provides drug services to the largest service population through five satellite centers located in Helena, Butte, Missoula, Anaconda and Bozeman. SMDP is a state program administered by the Department of Institutions, Alcohol and Drug Abuse Division.

Lighthouse, a residential therapeutic treatment program, located at Galen State Hospital provides statewide services.

Rimrock Guidance Foundation, a comprehensive alcohol and drug abuse treatment center, located in Billings, provides drug services throughout southcentral Montana, Region III.

Based upon FY 79 regional priorities, and high arrest statistics for drug abuse offenders, chemical dependency programs were continued within four state correctional institutions: Pine Hills School for Boys, Miles City; Swan River Youth Forest Camp; Montana State Prison, Deer Lodge, and Mountain View School, Helena.

Service coordination has involved local and regional agreements between drug facilities and other service programs, including comprehensive Mental Health Centers. Agreements with Mental Health Centers have involved reciprocal referral arrangements so that local mental health staff provide psychiatric evaluations of drug abuse clients and drug program staff provide diagnosis of mental health client drug abuse patterns and treatment alternatives.

In mental health regions where drug treatment services have not yet been established (I and II), Community Mental Health Centers provide drug abuse services to a limited number of patients. Services have included outpatient therapy, detoxification, aftercare, and chemotherapy.

Drug program staff and the Alcohol and Drug Abuse Division have assisted in these efforts through training programs for representatives of all regional Mental Health Centers.

Transitional Services (Community-Based Residential Treatment Facilities)

All five catchment areas have transitional and/or group home care facilities with two in Region V, 1 in Region IV, 4 in Region II, 6 in Region III and 1 in Region I. This is an increase of 2 over last years total. Further development of this service is an urgent priority to maintain continuity of care for discharged institutional patients. New resources need to be developed in communities to provide the very important transitional homes. It is a fact, that many patients would not have to live in the State Hospital if alternate living accommodations could be located near treatment services. A survey of Warm Springs State Hospital on 4/13/79 revealed that 45 patients were discharge-ready and waiting for a transitional living placement in the community. Transitional homes can provide continuity of care to many deinstitutionalized Warm Springs State Hospital patients and alleviate inappropriate placements into Warm Springs State Hospital. An application has been made for H.U.D. Section 202 demonstration funding.

A licensure procedure for mental health transitional homes is in effect. Several meetings have been held with the Department of Health and Environmental Sciences, Division of Food and Consumer Safety Bureau. A

strategy for drafting additional administrative rules is being developed which will accomplish more extensive licensing standards for transitional homes.

Initially, residents of transitional care facilities tend to be frightened and uneasy if they have undergone many years of institutionalization. Usually, they attend day treatment and sheltered workshops and can make good progress in independent living skills.

A variety of forms of transitional care has developed in Montana. Region III operates three group homes in conjunction with the Deaconess Hospital and has two community cluster homes for more independent living. With the stimulus of the Community Support Project this center has recently developed an apartment cluster home for more independent living than the two previously mentioned type facilities. In Region V, an independent boarding home is contracting with the mental health centers and providing care for five patients from Warm Springs State Hospital. A new group home opened in Kalispell in 1978. In Region II, the center has an agreement with the Salvation Army to provide care for 15 patients from Warm Springs State Hospital. In addition the Downtowner Hotel is working closely with the center and providing care for five patients. A new group home and apartment cluster opened in 1978-79. Region IV has its own transitional home. Region I has a transitional home adjacent to the general hospital. All of the regions are consulting with those private nursing home facilities which have taken patients from W.S.S.H. and provide direct service as requested.

Follow-up Care For the Chronically Mentally Ill

The State Mental Health Authority is required to provide assistance to the Regional Mental Health Centers to facilitate follow-up care and/or

follow along for residents who have been discharged from mental health facilities. This requirement is designed to assure adequate community support for those no longer in need of inpatient care, or day treatment with particular emphasis on the needs of patients discharged from Warm Springs State Hospital.

Starting with a specific cost-for-service contract in 1976 between the 5 centers and Warm Springs State Hospital, each regional mental health center has delegated responsibility to an alternate service staff unit for follow-up care. Predischarge planning procedures are instituted at Warm Springs State Hospital involving a regional mental health staff member and Warm Springs State Hospital pre-release unit staff. The two teams discuss patient needs and community resources and submit a formal treatment plan. A formal treatment plan is necessary for all discharged patients. A formal Warm Springs State Hospital discharge policy has been implemented in March 1979. The Department of Social and Rehabilitation Services has been, and is, involved in placements in nursing homes and other community referral mechanisms are utilized. The case management system is interlocked with the formal treatment plan and facilitates treatment, rehabilitation, social and domiciliary needs being adequately addressed for each discharged Warm Springs State Hospital patient. However, there are differing concepts as to case management among regions. Evaluation and monitoring of the service is done by the Mental Health and Residential Services Division.

The responsible centers in each catchment area in the state are Eastern Montana Community Mental Health Center - Miles City, Northcentral Montana Community Mental Health Center - Great Falls, South Central Montana Regional Mental Health Center - Billings, Southwest Montana Mental Health Center - Helena, and Western Montana Regional Mental Health Center - Missoula.

Their follow-up personnel are responsible for the follow-up procedures throughout the regional mental health center catchment area.

Although the contract between Warm Springs State Hospital and the centers terminated on July 1, 1977, the legislature included the above mentioned services into the general fund appropriation for the FY 78-79 biennium but at a decreased level. In January 1978 federal participation was obtained under the Community Support Project.

A major thrust of the Community Support Project is to expand and increase follow-up care. Utilizing South Central Mental Health Center as a core service agency, a demonstration model has been developed and will continue to be refined for use throughout the state. Expanded program development starts with Region I on July 1, 1979, followed by Regions II and V on July 1, 1980 and Region IV on July 1, 1981. Major components of the model are the following:

1. Identify and reach out to the mentally disabled in the community.
2. Help mentally ill clients apply for income, medical and other benefits.
3. Provide 24 hour quick response crisis assistance and emergency residential care.
4. Provide psychosocial rehabilitation and supportive services e.g. help with employment training and employment, appropriate living arrangements and social opportunities.
5. Provide adequate medical and mental health care.
6. Offer backup support, assistance and consultation to families and community caring members.
7. Involve concerned community members.
8. Establish mechanisms to protect client rights.
9. Utilize case management system.

None of the centers have all of these components fully in place at this time but substantial progress has been made in the past year in

developing services for the chronically mentally ill and a formal program development strategy has been formulated to implement these components over a three year period.

Minorities Services

The major minority group in Montana is Native Americans. There are seven Indian reservations. The Indian Health Service does operate some minimal mental health services on the reservations but there is a need for more extensive services that will also cover the off-reservation Indians. Regions I and III mental health centers have contracts with reservations whereby Indian paraprofessionals are hired by the tribe to work full time on the reservation but obtain supervision and consultation from the center. Region V has a Ph.D. psychologist working almost full time on the Flathead Reservation. Region II, III and IV offer services on an as-needed basis.

Four CMHCs have developed plans for Native Americans and these programs will be monitored during the 1980 site evaluations.

Rape Services

Prevention of rape and services to victims of rape is mandated by P.L. 94-63. In four of the regions volunteer organizations have been developed and the centers do consult with, provide training to and assist as needed. In Region I where no such agency exists the center has an on-going relationship with the police who do call and refer as needed for services.

Public Mental Hospital

Title 53, Chapter 21, M.C.A. defines the process for entry into Warm Springs State Hospital by persons suffering from serious mental illness. The institution's primary concern is to provide inpatient care and intensive treatment to mentally ill persons. State hospital care is seen as a vital link in the total chain of mental health services.

1975 represented a benchmark year for mental health services in Montana. Recognizing the state's responsibility to initiate a comprehensive program of deinstitutionalization of the residents of state institutions, the Department in cooperation with staff at Warm Springs undertook a major reorganization of that facility. Two primary aspects of the reorganization were the centralization of clinical services and the establishment of a new department of Quality Assurance. The functions of the latter are detailed in Exhibit 10 on page 55. The major treatment units were divided into regional units corresponding to the five mental health catchment areas of the state. In addition, special units for children, geriatrics, forensics, physically ill, schizophrenic and mentally retarded were also established. One of the principle benefits of the reorganization is the advantage of a multi-disciplinary approach to care and treatment. Such an organizational structure enhanced communication with the community programs and facilitated the transfer of patients from the hospital to the community while maintaining a reasonable level of continuity of care. Montana's deinstitutionalization program has had a bearing on the dramatic change in the census of the hospital from 904 in July 1975 to 424 in April 1978 - a 53% reduction. Exhibit (7) presents the most recent patient population distribution at Warm Springs.

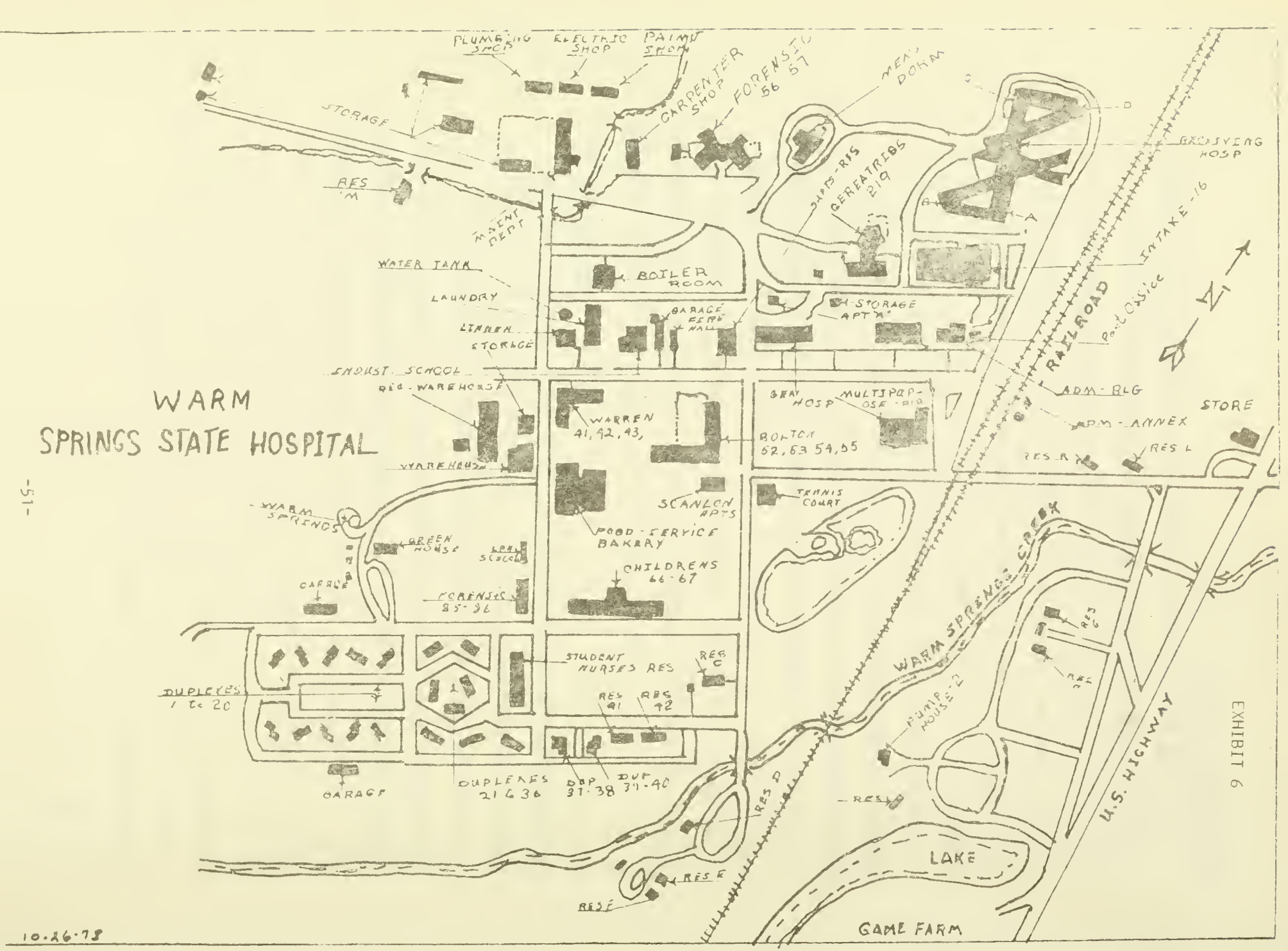


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EXHIBIT 6

10-26-78

EXHIBIT 7

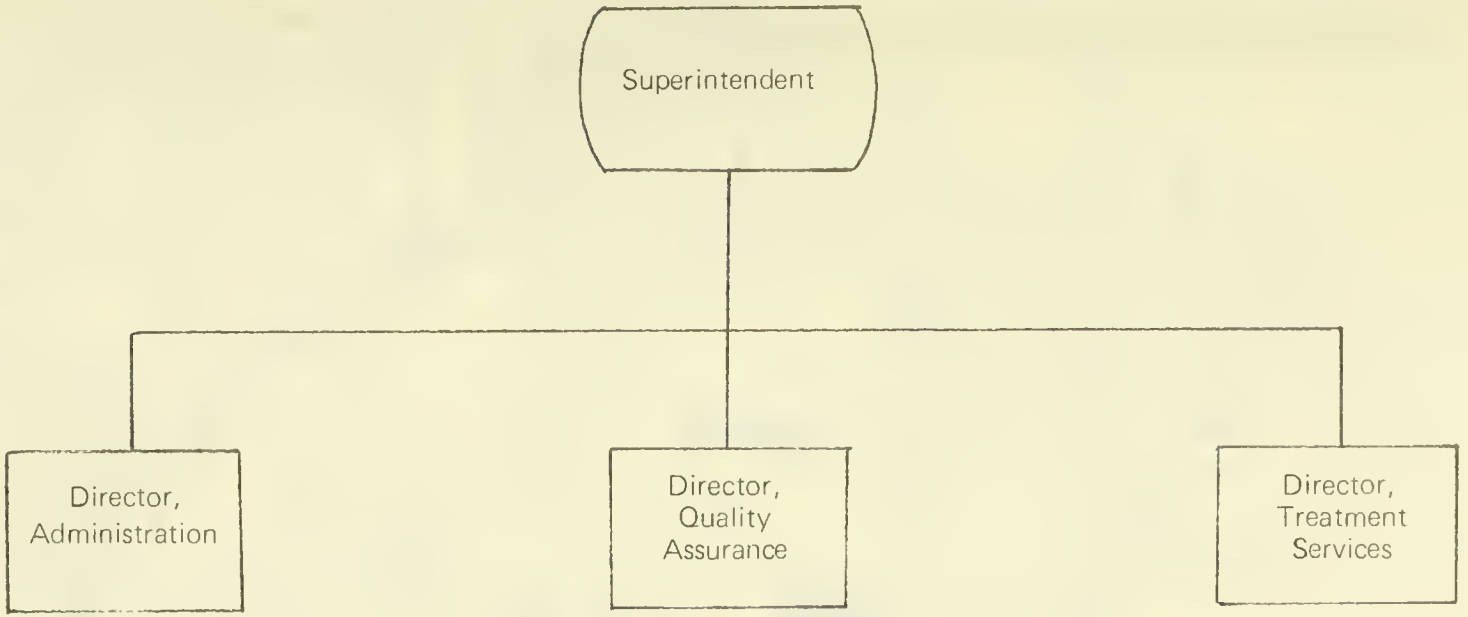
WARM SPRINGS STATE HOSPITAL
PATIENTS BY SPECIAL UNIT

June 12, 1979

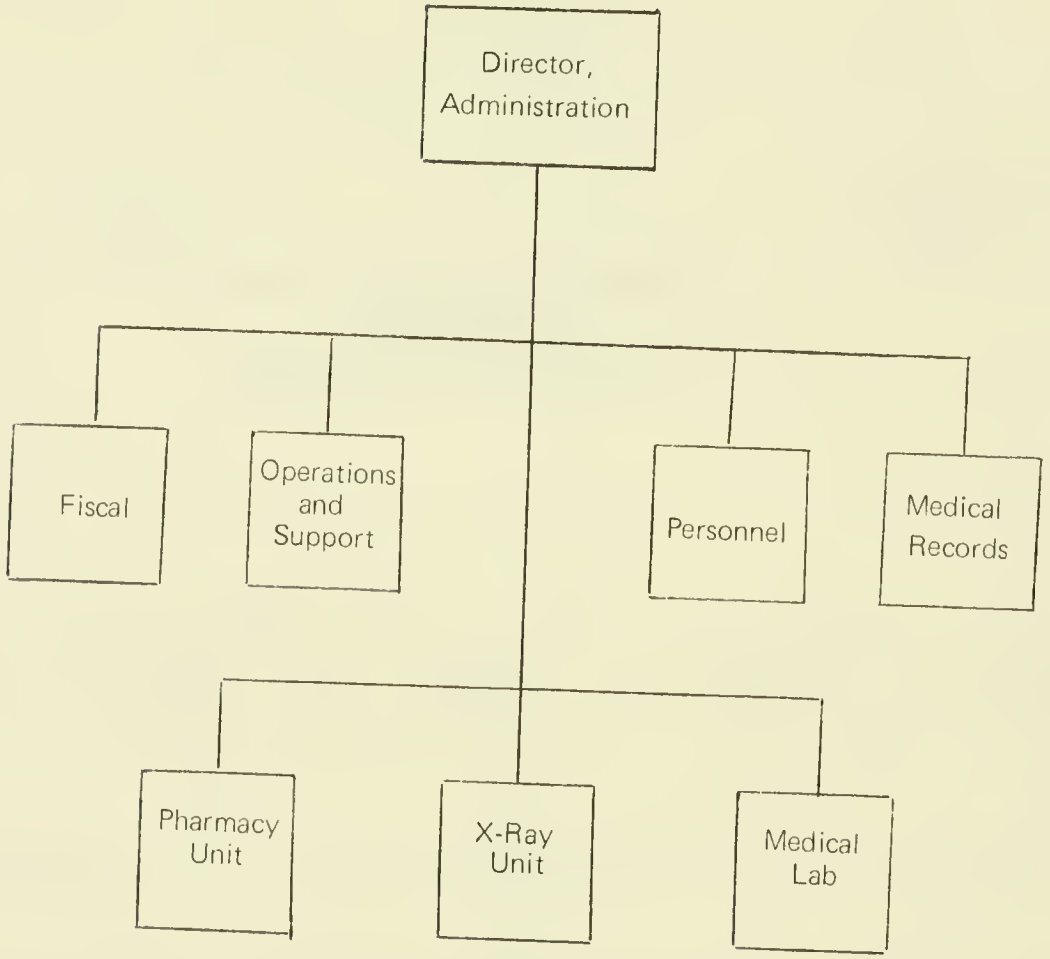
	BED CAPACITY	PRESENT RESIDENTS MEN	PRESENT RESIDENTS WOMEN
Children's Program	35	21	8
Extended Care	175	98	48
Forensic and Retarded	76	41	13
Geriatric	60	26	21
Intake	24	11	06
Pre Release	24	7	3
Short Term	76	27	24
TOTAL	470	231	123

Total Patients in Hospital 6/12/79 - 354

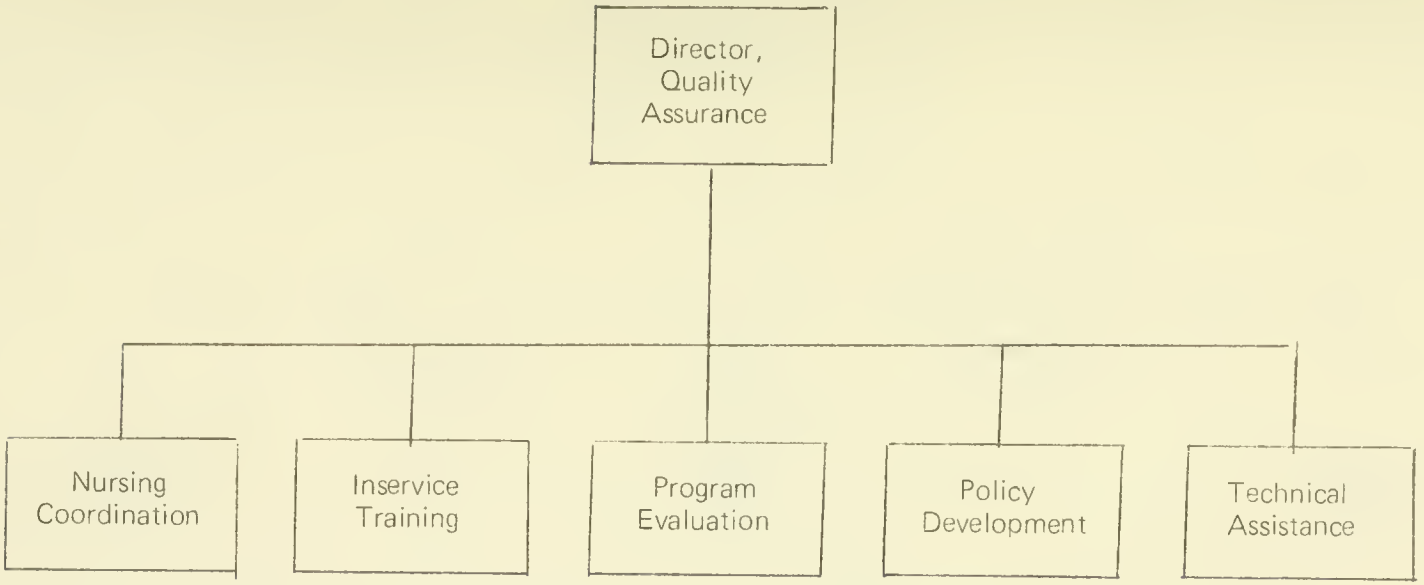
Total Patients in Hospital 7/1/75 - 904



WARM SPRINGS STATE HOSPITAL
ORGANIZATION

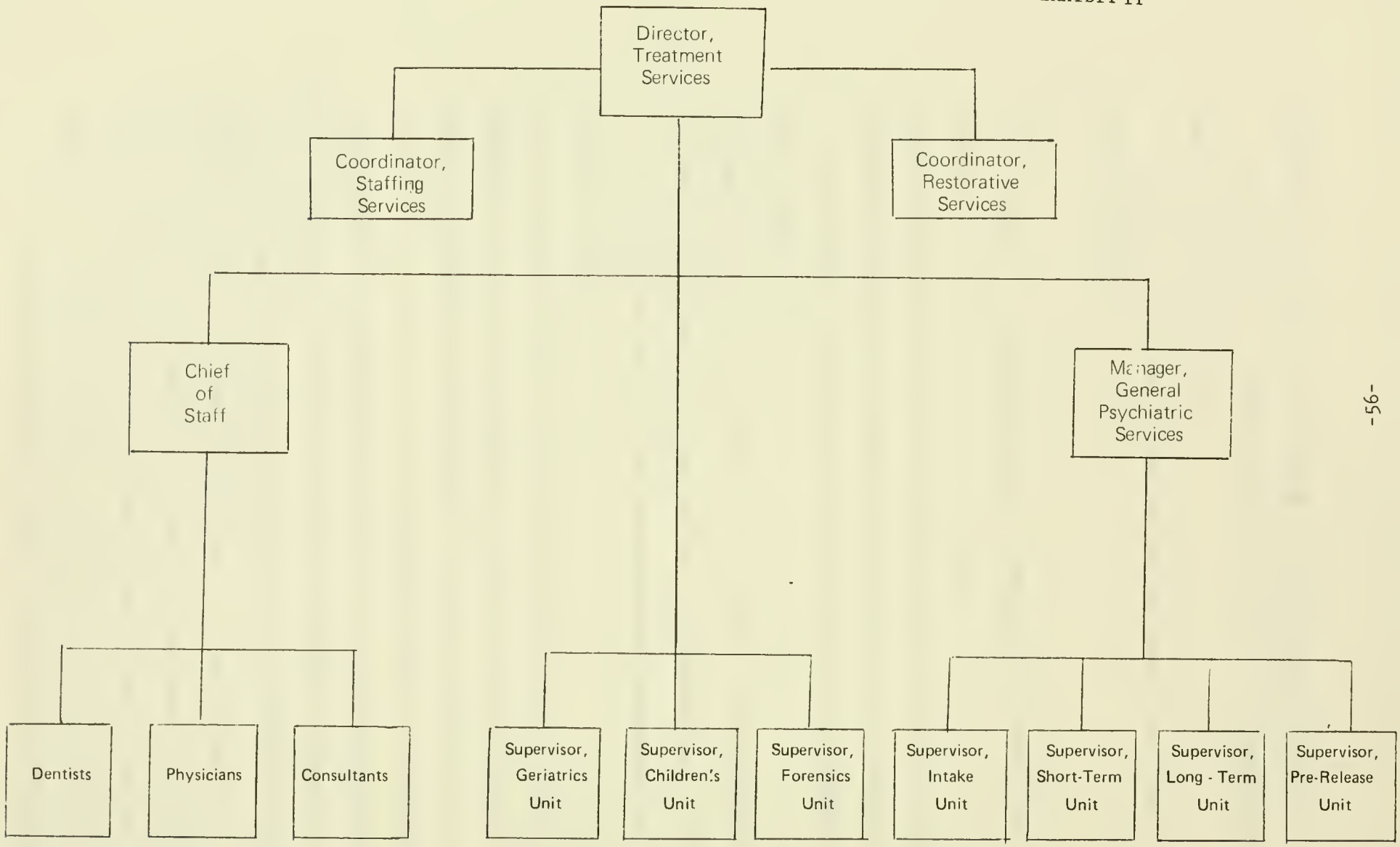


WARM SPRINGS STATE HOSPITAL
ORGANIZATION
ADMINISTRATION FUNCTIONS



WARM SPRINGS STATE HOSPITAL
ORGANIZATION
QUALITY ASSURANCE FUNCTIONS

EXHIBIT 11



WARM SPRINGS STATE HOSPITAL
ORGANIZATION
TREATMENT SERVICES

With the dramatic reduction in the census of the hospital and the concomitant increase in availability of community based programs, the role of the state hospital in the overall mental health service delivery system of Montana has changed. In May 1978, Warm Springs was again reorganized. Exhibits (8-9-10-11) presents the new organizational structure of the hospital. While the specialty units have been retained, the regional units have been realigned into two major divisions - one for the acutely ill and one for the long term severely mentally ill. In addition, an intake unit has been created that will serve as an evaluation unit for the entire hospital, and a pre-release unit has been established to provide a transition period for patients who are returning to the community. Actual implementation of the reorganization has been completed.

It is the firm belief of the Department and staff of Warm Springs that the new organization of the hospital will appreciably enhance the hospital's legitimate function as a vital link in Montana's mental health system.

Joint planning between the Department of Social and Rehabilitation Services, Division of Developmental Disabilities and the Department of Institutions, Mental Health and Residential Services Division, has spelled out criteria for provision of community services for the developmentally disabled who are presently at Warm Springs State Hospital.

Board of Visitors

The Board of Visitors is the quality assurance agency for the mental commitment and treatment act.

Its purpose is to assure that the treatment of all persons voluntarily admitted or involuntarily committed to a mental health facility is humane

and decent and meets the standards established by law.

The Board makes an inspection at least annually of every mental health facility within the state which is providing evaluation and treatment for mentally ill persons. This inspection includes overview of the physical plant, including residential and treatment areas, and an inquiry into general and individual treatment plans being used in the facility. The Board of Visitors assists residents at mental health facilities to resolve any grievances they may have concerning their commitment or course of treatment.

If the Board of Visitors determines that a mental health facility is failing to comply with the requirements of the mental commitment and treatment act in regard to its physical plant, or the care or treatment of residents, it reports its findings to the next of kin or guardian of any patient involved, the responsible person appointed by the court for any patient involved, the professional person in change of the facility, the director of the Department of Institutions, and the district court which has jurisdiction over the facility. The Board makes an annual report to the Governor and reports to each regular session of the Montana Legislature (38-1330(8)). The Board may hire staff to assist it in carrying out its duties (38-1330 (9)).

Priorities for Expanded Mental Health Programs

Over the next five years, each of the above current problem areas are in need of improvement. The state agency has outlined six major priorities for mental health programs. They are:

- Chronically mentally ill
- Children
- Elderly
- Unserved and Underserved
- Acutely mentally ill

In addition to the above priorities, there is a need for increased consultation, education and preventive services designed to promote the mental health of all citizens in Montana and a need for improved manpower development and training programs to insure quality mental health care for those who seek or require it.

With these priorities in mind, the following mission statement and goals and objectives have been outlined to help insure mental health for all persons residing in Montana.

MISSION STATEMENT

A primary mission of the Department of Institutions is to facilitate the provision of an integrated network of comprehensive mental health services on an equal basis throughout Montana. These services shall be based upon demonstrated needs, attested to by its citizens and will include both direct and indirect services. Services of high quality at the least cost possible will relate to rural-oriented guidelines and standards as appropriate.

GOALS AND OBJECTIVES

The Montana Department of Institutions has the overall responsibility for coordination of mental health programs supported by local, state and federal funds. In order to assure optimal responsiveness to the needs of Montana citizens, it is necessary to have an ongoing planning process which sets forth the major philosophical and operational direction of the program and which identifies the action steps required to achieve desired ends.

Further, progress toward meeting needs of citizens must be monitored on a regular basis. Thus, the goals and objectives outlined below provide

a mechanism for future planning and evaluation. They are intended to communicate to federal, state and local organizations the overall direction of the Department of Institutions in further development of community and institutional mental health services. Objectives by their very nature are planned or desired outcomes. For each of the next five years, objectives of this plan will be reviewed in-depth with increased state agency capacity to evaluate program results. As this occurs, increased knowledge of population needs and service resources will be available and may cause revision of present objectives.

The Department mission and purpose, which establish the foundation for the state public mental health delivery system, are reflected in the following goals, principles, and objectives. The goals represent a unifying force that is intended to integrate the various elements of the plan. As each goal is interrelated and interdependent upon the others, their order of listing does not indicate relative priority.

The following objectives are intended (a) to describe the necessary steps toward accomplishment of the stated goals, and (b) to provide a means of assessing progress. Unlike goals, which should remain relatively constant, these objectives may reflect the principle of flexibility as they respond to changing needs, resources, and other factors that evolve during the continuous planning process.

GOALS 1-4

#1. To preserve and maintain the orderly development of a unified and integrated statewide mental health service delivery network which would include both public and private organizations and individuals serving the mentally disturbed or disabled.

#2. To promote and provide high quality developmental and habilitative services within state administered and private non-profit programs which emphasize services to the following population groups.

- chronically mentally ill
- children
- elderly
- unserved and underserved
- acutely mentally ill

#3. To promote mental health for all citizens of Montana and to increase and improve services to mentally ill persons through:

- increased consultation services
- increased public knowledge of mental health services
- increased preventive activities
- improved manpower development and training

#4. To provide a unified comprehensive mental health network of services which:

- establishes and enforces quality of care standards
- is efficient and based on specific area needs
- is cost-effective and financially accountable
- is evaluated

GOAL #1

To preserve and maintain the orderly development of a unified and integrated statewide mental health service delivery network which would include both public and private organizations and individuals serving the mentally disturbed or disabled.

The intent of this goal is to stress the principle of cooperation as a basic value in the orderly development of mental health programming in a rural state. The goal emphasizes the strengths of a single, unified effort to insure the health and safety of individuals whether they are participating in community programs operated by the community mental health center, or under the care of private mental health practitioners, or in state operated residential treatment facilities or involved with other social and health agencies. The sharing of services and increased communication among all sectors of the mental health service delivery system is encouraged. Conversely, the principle of competetiveness for clientele or for limited resources is viewed as counter-productive to the achievement of this long range goal. Linkage with mainstream social and health agencies is seen as a necessary and vital ingredient in this goal.

OBJECTIVES

1. By December 30, 1980, to encourage, plan for and develop a stable long-range view of what the statewide mental health service delivery network should be 5 years hence. The planning process should include the following concepts:

    a) a single state plan for mental health services;

    b) a stable funding base for implementing the mental health plan; and

    (Responsible Organization - MHRSD)

c) legislation and/or administrative act necessary to implement the above. (Responsible organization: Governor's Office)

2. By October 1, 1979 an ad hoc interagency planning and policy committee will be established to formally delineate the specific roles and responsibilities of each unit within the mental health service delivery system to include all mental health services with particular emphasis on care of chronically mentally ill. Consequent to identification of roles and responsibilities interagency policies and procedures will be developed as needed to facilitate ongoing operation of the overall service delivery system. It is anticipated that members of the committee will include Superintendents, CMHC Directors/Board members, representatives from Governor's Office and Department of Institutions staff, Social and Rehabilitation Services, the Mental Health Advisory Committee, representatives of the Montana Psychiatric, Medical and Psychological Associations, the Mental Health Association and representatives of other private sector organizations. The committee will meet at least quarterly during FY 1980. (Responsible organization: MHRSD)

3. By September 30, 1979, the Community Support Project shall perfect and further develop and demonstrate a model for helping the severely mentally disabled adult in the South Central Montana Mental Health Center. Also, on 7/1/79 the Community Support Project will begin program development for this sector of the population in Region I, Eastern Montana Mental Health Center.
(Responsible organizations: MHRSD, SCMMHC, and EMMHC)

4. By December 1, 1979, have a meeting of Health Systems Agency planners, Department of Health and Environmental Sciences, Division of Alcohol and Drug Abuse and representatives of the Mental Health and Residential Services Division to plan for development of a single state plan for mental health services. (Responsible organization: MHRSD)

5. A completely new and revised state plan developed with input from the community mental health centers, the residential institutions, private providers and the Mental Health Advisory Committee, will be completed by June 1, 1980. (Responsible organization: MHRSD)

6. By October 1, 1979, a Mental Health Advisory Committee, consisting of a majority of mental health consumers, will be created as an advisory body to the Mental Health and Residential Services Division.
(Responsible organization: MHRSD)

GOAL #2

To promote and provide high quality developmental and habilitative services within state administered and private non-profit programs which emphasize services to the following population groups.

- chronically mentally ill
- children
- elderly
- unserved and underserved
- acutely mentally ill

The expectation of this goal is to strengthen, quantify and qualify a broad range of services and treatment opportunities to those populations at

risk who are too often neglected and ignored. It has a two pronged approach: expanding and intensifying existing services as well as broadening the clientele to include sectors of the population having the greatest need.

OBJECTIVES

1. Between 7/1/79 and 6/30/80 all patients at Warm Springs State Hospital, Galen State Hospital, and the Center for the Aged will be reviewed on an ongoing basis to determine appropriateness of current placement. Specific plans, including time tables, will be established for transfer of those patients determined to be currently inappropriately placed to facilities appropriate to their individual needs.
   (Responsible organization: MHRSD)

2. Between 7/1/79 and 6/30/80 a multi-discipline team will continue to function on a quarterly basis for purposes of peer review, and/or quality assurance of professional care and treatment at WSSH.
   (Responsible organization: WSSH and Center for the Aged)

3. By June 30, 1980 the annual site evaluation will have been completed on all CMHCs. These reviews will include assessment of Center plans for the following target groups; elderly, seriously emotionally disturbed children, chronically mentally ill, Native Americans. Additional considerations will be given to Center provision of:

   a) a continuum of community based transition and/or group care facility development in each catchment area to provide appropriate living arrangements for mentally ill clients, so that on 5/1/80 no more than 10% of the adult population at WSSH will be on waiting lists for community mental health residential care.

b) Daycare treatment: By June 1980, each CMHC day program will be placing emphasis on the following 3 areas: community living skills, job seeking skills and social skills.

c) By January 1980, each catchment area will have developed a formal ongoing relationship through close interaction with existing mainstream agencies for the purpose of providing a training and employment assistance program for the chronically mentally ill client.

4. By December 1, 1979 an intensive care facility for severely emotionally disturbed children will have been established. (Responsible organization: OBPP, MHRSD and CMHC)

5. By June, 1980 a preliminary meeting with the community mental health centers will be held to develop an action plan and request for financial support to be submitted to the 1981 Legislature.

6. During FY 1980, the Interagency Screening Committee on Emotionally Disturbed Children will continue to review all referrals of emotionally disturbed children to residential institutions operated or paid for by state funds.

GOAL #3

To promote mental health for all citizens of Montana and to increase and improve services to mentally ill persons through:

- increased consultation services
- increased public knowledge of mental health services
- increased preventive activities
- improved manpower development and training

Consultation services primarily refers to the assistance given other human services professionals in the assessment of their attitudes and improvement of their skills in working with mentally ill persons and their families. These professionals include school personnel, court and law enforcement personnel, public health nurses, social service workers, agricultural extension workers, clergymen, physicians, and others. These individuals are on the front-lines of providing for the communities' mental health needs and logically should look toward the CMHC's for consultation and training services. The more that their attitude toward mental health needs and services are shaped by understanding and awareness, and their own skills improve in working with the various categories of mentally ill persons, the more effective they will be in the areas of early detection, early diagnosis, and early intervention. The prevention of serious mental health problems and more appropriate referrals to both the CMHC's and the state hospital should result.

Preventive educational services should also be directed at many potential victims of mental illness. Many of these people will not be noticeably disturbed, but nevertheless, are functioning below their potential capacities. This goal is intended to promote mental health in individuals, families, and communities by helping local citizens acquire knowledge, understanding attitudes and behaviors that will foster their own and the community's mental well-being. The intent of this goal is to support primary and secondary intervention at the local community level, not as a less important adjunct to traditional direct service methods, but as an equally important mental health provision towards prevention. Major areas of concern to be addressed are the determination of what modalities are best to prevention at the community level, the lack of data on the impact of preventive programs, and how specific problems of the aged, children, and ethnic minorities (most significantly the Indian population) can be addressed effectively.

Manpower development and training needs are considerable throughout the state,

and even in the rural outreaches of this rural state. A special effort should be made as a first step towards the business of prevention by direct and aggressive confrontation with the various issues related to manpower development.

OBJECTIVES

1. All CMHC's will have delegated to a person by September 1, 1980, the responsibilities for a Consultation and Education program that incorporates aggressive reaching out to other human service groups in the catchment area. (Responsible organization: CMHCs)

2. By June 30, 1980, 2 workshops will have been held between mental health service providers and correctional workers to address such issues as commitment procedures, discharge policies and interrelationships between the two fields.
(Responsible organization: MHRSD)

3. By June, 1980 the MHRSD will have conducted one joint public information activity with the Mental Health Association of Montana.
(Responsible organization: MHRSD and MH Association)

4. Between July 1, 1979 and June 30, 1980, the Mental Health and Residential Services Division will provide periodic releases to local news media on various aspects of mental health in Montana.
(Responsible organization: MHRSD)

5. By January 1980, an initial assessment of specific manpower needs for Montana with established priorities for implementation will be effected.

6. Between 7/1/79 and 6/30/80 the Mental Health and Residential Services Division will provide technical assistance to mental health centers and institutions as needed.

GOAL #4

To provide a unified comprehensive mental health network of services which:

- establishes and enforces quality of care standards
- is efficient and based on specific area needs
- is cost-effective and financially accountable
- is evaluated and reported upon

Sound management principles are essential to effective and responsible mental health services. These principles include an objective determination of need; the aggressive seeking of alternate sources of funding; the provision of effective services in the most efficient manner; and the evaluation of the impact of the services. Also necessary to this process is meaningful coordination with the state hospital at Warm Springs, other CMHC's and with other agencies delivering services which have a bearing on the mental health of individuals and communities; and the existence and enforcement of standards.

A long-range aspect of this goal is the continued development of a sound base of fiscal support for the mental health system which will rely on the utilization of a combination of funding sources including federal, state, local, third party, appropriate fee collections, and other potential funding sources. The principle of multiple-funding attempts to insure an adequately sound base for program maintenance and development, and to insure the local integrity and individuality of each catchment area.

The intent of this goal is to insure quality services and effective and appropriate evaluation while maintaining a genuine respect and support of the concept that administrative control and decision-making should be kept as

close as possible to the point of production, i.e., the center level. An effective state evaluated program should recognize responsibility to insure relatively equal services to all Montana citizens while permitting appropriate flexibility in recognition of differential catchment area needs and resources. A future cost-for-service formula will accomplish best the desire for (a) equal quality services that are uniformly evaluated, and (b) local autonomy to administer and provide those services as deemed best by local center administrators and clinical personnel.

OBJECTIVES

1. By January 1980, MHRSD and CMHCs will have reviewed and updated the uniform management information system that includes patient and financial data.
   (Responsible organization: CMHC Boards, MHRSD)

2. By September 1979, each Center having participated in the development of a standards document for CMHC services will have developed an agreed upon basis for establishing a minimum level of compliance with the standards.
   (Responsible organization: MHRSD)

3. During FY 1980, MHRSD will utilize the above standards in the annual site evaluation of the CMHCs.
   (Responsible organization: MHRSD)

4. During FY 1981, MHRSD in cooperation with CMHCs, will establish a basis and schedule of penalties to be applied in event of non-compliance.
(Responsible organization: MHRSD and CMHCs)

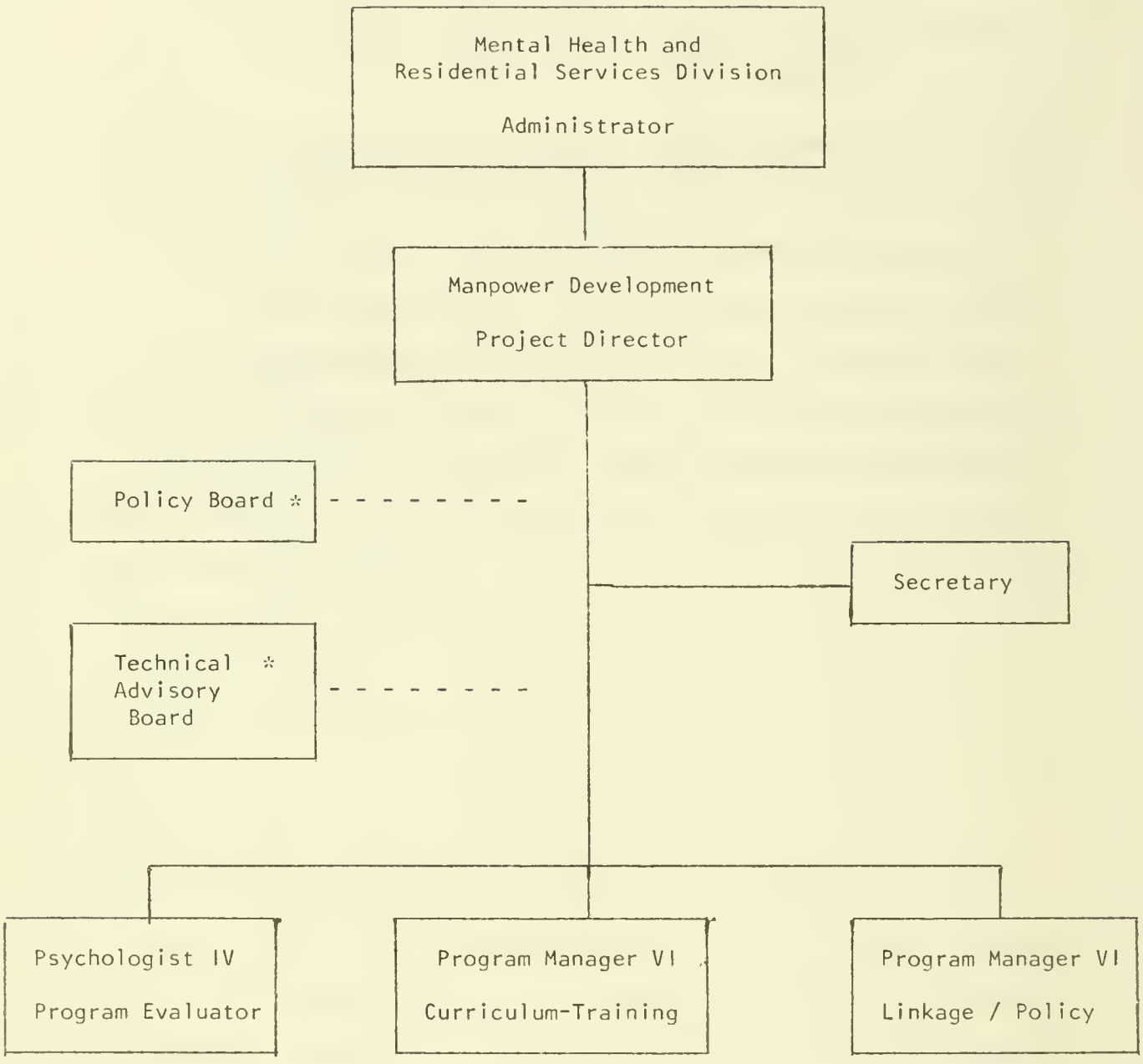
5. During FY 1980, the MHRSD will develop quarterly and a year-end report on achievement of goals and objectives in the '80 State Plan. The reports shall be distributed to all relevant mental health organizations and agencies and specifically to CMHCs, Governor's Office, Regional NIMH Office, Board of Visitors, Director of Department of Institutions, Mental Health and Residential Services Division staff, Mental Health Advisory Committee, Superintendent of WSSH and HSA.

Manpower

Review of Manpower Activities

The 1978 Montana State Plan identified the mental health work force and discussed projected personnel needs, problems, priorities, and goals. The 1979 Plan presented a revised description of staff employed and personnel vacancies throughout the system. In addition, the 1979 Plan identified major issues confronting Manpower Development in Montana and made brief general statements of long-range goals and objectives. The goals and objectives set forth in the 1979 Plan provided the impetus for an NIMH Mental Health Manpower Development proposal which was awarded in July 1978. Because the major issues facing Mental Health Manpower Development in Montana have not changed appreciably since the 1979 Plan, those issues will not be reiterated in this Plan. Rather, the manpower portion of the 1980 Plan will focus on the creation of the Montana Manpower Development Project, its goals and objectives, and their progress in the past year. (Appendix E) For rationale and discussion of issues related to these objectives, the reader is asked to reference the 1979 Plan.

The Mental Health Manpower Project, funded in July 1978, is administered by a full-time Project Director, who is responsible to the Administrator of the Mental Health and Residential Services Division. Additionally the staff includes three full-time professionals and a full-time secretary. The structure of the project within the Mental Health and Residential Services Division is depicted in the organizational chart below with primary areas of responsibility designated.



* Policy and Technical Boards are not yet organized, but are depicted here because they will be established this year.

Since the initial funding of the Mental Health Manpower Project in July 1978, there has been a shift in emphasis from education and training as a primary focus to an expanded view of the Manpower Project as the locus for broader manpower policy planning effecting program and policy change on a wider horizon.

The overall mission of the Manpower Project is to marshal the human resources necessary to improve the ability of the Montana mental health system to respond to the State's mental health needs and problems. Within this broad statement of purpose, the Manpower Project has two major long-range goals which are:

1. To improve coordination with both public and private agencies which will result in long-range policy agreements impacting upon mental health service. Such agreements will influence the production, regulation, utilization, deployment, retention, and evaluation of mental health personnel.
2. To implement specific training and educational programs that address themselves to immediate manpower gaps in Montana.

Within each manpower goal there are five major objectives which are targets for accomplishment within the next project year.

GOAL 1: Coordination and Policy Development

Objective 1. Leadership Development - To present two major workshops; one, for state level staff, and one for CMHC satellite directors, designed to improve management capability.

Objective 2. System Cooperation - To coordinate manpower activities with the State's Community Support Project program, the state hospital and other institutions as appropriate, as well as the Mental Health and Residential Services Division, and the community.

Objective 3. Advisory Board Development - To strengthen Regional Governing and Advisory Boards through training seminars designed to build upon mental health knowledge and values; with a special focus upon role clarification and function.

Objective 4. Prevention Through Education - In conjunction with the Mental Health Association, to work cooperatively with a variety of agencies to promote the mental health of children, the elderly and underserved populations through prevention.

Objective 5. Licensure Policy Change - To develop and establish standardized criteria for program licensure, facility licensure and clinical personnel licensure, with categorical standards for each discipline.

Goal 2: Training and Educational Programs

Objective 1. Pre-Service Education - To maturate a contractual arrangement with the University of Montana to provide in-state training of pre-doctoral psychology students.

Objective 2. Education and Development - To broaden the mental health network continuing education needs to include institutions, CMHCs, primary providers, (e.g. doctors and clergy), private providers, natural providers, and state mental health staff. Utilizing matching of identified needs with existing resources and opportunities.

Objective 3. Paraprofessional Incorporation - To incorporate into the existing mental health system trained paraprofessionals with specialized education and field experiences that emphasize rural outreach and relationship skills that engage the mental health needs of minority populations.

Objective 4. Volunteer Integration - To develop a comprehensive statewide volunteer system which allows for unique regional and local variations.

Objective 5. Natural Provider Development - To develop and maintain natural provider training in the use of communication and basic helping skills and knowledge and use of referral sources, toward consistent utilization and retention of these key persons and groups in the community.

COORDINATION OF PLANNING

Many public and private agencies throughout the State of Montana are involved in the provision of human services. These human service agencies often have functions and responsibilities which overlap or duplicate other human service agency efforts. Because these agencies have separate organization structures the potential for duplicated services, unmet service needs, and inefficient delivery of multiple services to individuals is significant. The Department of Institutions recognizes the need for a coordinated approach to services planning and delivery, and is committed to this coordination in the provision of mental health services. This coordination occurs as follows:

Health Planning

It is anticipated that the State Plan for Mental Health will stand as a companion document to the State Plan for Health for a total view of what should be done in Montana in regard to total health services. The present health planning organization within Montana changed October 1, 1976 as per Public Law 93-641. The Montana Health Systems Agency has been established to develop health plans for the sub-area planning districts of Montana. To coordinate planning efforts, the Montana Advisory Council for Mental Health and the Mental Health and Residential Services Division are participating with the Health Systems Agency and the State Planning and Health Development Agency in evaluation of planning for health in mental health programs throughout the state.

-Licensing requirements for community based group homes or alternate living facilities.

-Approval of applications for construction of mental health facilities.

-Coordination of community-based health and mental health programs and personnel.

Further, coordination between State Health and Mental Health agencies and Regional Mental Health programs is enhanced by representation on the Statewide Health Coordinating Council. Coordination is also facilitated on an areawide basis by representation of the Council of Regional Mental Health Boards on the executive division of the Montana Health Systems Agency Governing Board. The Regional Director of the South Central Mental Health Center serves as Chairman of the Statewide Coordinating Council as well as the Governing Board of the Health Systems Agency.

At present, this Plan is consistent with the State Health Plan published in August 1974 under Section 1524(c) (2) of the Public Health Services Act. The State Mental Health Plan will be given to the Statewide Health Coordinating Council and the Health Systems Agency Governing Board for review and approval.

Other Human Services

State agencies responsible for human services meet at least twice a month. The purpose of the meetings are to coordinate planning among agencies for service delivery. Representatives include the Governor's Office, Department of Institutions, Social and Rehabilitation Services (State Title XX Agency), Community Affairs, and Health.

Alcohol and Drugs

The role of division administrators of the Alcohol and Drug Abuse Division and the Mental Health and Residential Services Division to insure that a coordinated effort in planning for community based service

delivery is an on-going process between the divisions' staff. An example of this coordinated effort is in the planning and conducting of site evaluations. Evaluation sections of both divisions have worked out a coordinated site evaluation schedule so they can evaluate community agencies providing both mental health and alcohol services during one site visit.

Community Planning

As stated in the purpose of the Plan, the Department of Institutions aims to provide a mechanism for communication between the Department and other local organizations involved in the delivery of mental health services. Communication is seen as a necessity for responsive and efficient services. No one center, agency or facility can alone provide adequate services to meet the myriad needs of the citizenry. It is necessary to establish a climate of mutual cooperation and understanding in order to obtain comprehensive care.

As previously discussed, the Community Support Unit within the Mental Health and Residential Services Division is taking the lead role in developing a support system which will rely on the close interaction between mental health service agencies and mainline agencies to improve community care for the mentally ill.

IV

APPENDIX

APPENDIX A

SURVEY OF MENTAL HEALTH NEEDS AND RESOURCES

OVERVIEW

The purpose of the Mental Health needs and resources survey was to determine relative and potential need for Mental Health programs among the five regional catchment areas. Results indicate that Region I, Eastern Montana, is the region with the highest potential need. The 2nd ranking region is region V. The remaining three regions are ranked #3 as they all have extensive needs and the difference between them is minimal.

The ranking of regions was determined by a statistical analysis of two variables:

- -The prevalence of individuals in "high risk" of needing mental health services; and,
- -the extent of mental health services presently available within each regional catchment area.

The survey was performed with the best available uniform data to gain a broad perspective of potential needs for new or expanded programs. Results do not indicate the size, number or site-location of new facilities. The state agency is aware of the numerous variables which must be assessed in order to reasonably plan for additional services. Some variables are:

- -Availability of required financial and manpower resources.
- -Transportation constraints in extremely rural counties.
- -Residence of current service population including institutionalized and non-institutionalized patients.

Because Regional Mental Health Boards are the primary organization responsible for planning and implementing additional mental health facilities, survey results are intended to provide guidance in these efforts.

NEEDS SURVEY

The needs survey was conducted to identify "high risk populations" in terms of relative and potential need for mental health services. This determination was based on the prevalence of weighted demographic, social and economic indicators in each regional catchment area. These indicators are known to correlate with admission rates to mental health facilities, and for the most part, provide the best account of variation in small area demographic characteristics. The following lists the socioeconomic and demographic indicators recommended by the Department of Health, Education and Welfare, and briefly describes the reasons for selecting additional social and health indicators.

SOCIOECONOMIC AND DEMOGRAPHIC INDICATORS - 1970 CENSUS STATISTICS

.Percent of males 16 years and over who are in a low occupation status.

.Percent of families below poverty level.

.Youth dependency ratio (i.e. persons under 18 years per 100 persons 18-64 years).

.Aged dependency ratio (i.e. persons 65 and over per 100 persons 18-64 years).

.Percent of household population in housing units with 1.01 or more persons per room.

Draft (2-17-76) Federal Guidelines for the Preparation of State

Plans or Comprehensive Mental Health Services (PL 94-63) - Alcohol, Drug Abuse, and Mental Health Administration, National Institute of Mental Health - Division of Mental Health Service Programs.

.Percent of household population who moved into present residence - 1969-1970, i.e. recent movers.

.Indian population as a percent of total catchment area population.

OTHER SOCIAL AND HEALTH INDICATORS

.Marriage dissolution ratio (1974) i.e. number of divorces and annulments per 1,000 persons. This characteristic is generally considered to have an adverse affect on individuals and increases the potential need for mental health services. Further, approximately 4,470 children were affected by some 3,940 marital dissolutions in Montana during 1974. (Source: 1974 Montana Vital Statistics - Bureau of Records and Statistics.)

.Infant mortality ratio (5 year period - 1970-1974) i.e. number of deaths under one year of age per 1,000 live births. This characteristic tends to be highest among the poor and minority segments, and is consistently associated with a large number of stress producing factors. (Source: 1974 Montana Vital Statistics - Bureau of Records and Statistics.)

.Suicide ratio (1974) i.e. number of suicides per 1,000 persons. Although it is recognized that data on suicides can be considerably affected by the way in which deaths are recorded at the local level, this characteristic is considered to be of clinical importance. (Source: 1974 Montana Vital Statistics - Bureau of Records and Vital Statistics.)

.Public Welfare Recipient Ratio (1976) i.e. number of recipients

receiving medical assistance per 1,000 persons. This population is generally highly represented with broken families, handicapped individuals, aged persons, and young children.

Numerical values or all indicators were converted to percentages or ratios to provide a basis or comparison and ranking between catchment areas.

WEIGHTING

As displayed in Exhibits A3 and A4, of the eleven indicators, seven were judged to be of equal clinical importance in determining the relative need for mental health services and assigned a weight of one. The following criteria was used to assign a weight of two to the remaining four indicators:

.Aged and Youth Dependency Ratio, as indicated on Exhibit A4, these characteristics were emphasized due to the current mental health delivery system's deficiency in providing services to these target populations.

.Marriage dissolution ratio - Marriage dissolutions increased by 29% during the period 1970-1974. Further, this characteristic is known to have an adverse affect on children as previously discussed.

.Indian population as a percent of total county population.

RANKING

As displayed in Exhibits A2, A3, and A4, individual rankings for

each indicator were multiplied by the assigned weights and summed to determine final ranking.

RESOURCE SURVEY

The purpose of this survey was to describe and summarize mental health resources in each mental health region and to provide the necessary data for ranking regions in terms of mental health resources. The methodology used to conduct the survey consisted of the following activities:

-Review of available secondary data as follows:

.NIMH Inventory of Comprehensive Community Mental Health Centers (1976).

.Department of Social and Rehabilitative Services (SRS) Adult and Family Services Division - List of Foster Care for Developmentally Disabled, January 1, 1976.

.Department of Social Services and Personnel Services (Payroll) - Warm Springs State Hospital.

.Commission of Higher Education - Psychologists in the State University System.

.Superintendent of Public Instruction, Special Education Program - Psychologists in the State Public School System.

.Bureau of Addictive Diseases - Department of Institutions - Alcohol and Drug Program Resources List.

.State of Montana Board of Psychologists - List of Licensed Psychologists.

.Comprehensive Health Planning Division - Health Manpower in Montana (January 1975).

.State Department of Health and Environmental Sciences - Division of Hospital and Medical Facilities - Licensed Hospitals and Long Term Care Facilities.

-Telephone interviews and,

-Written communication with regional community mental health personnel to augment and verify data collected through review of secondary data.

-Location of present resources;

-type and ownership of facilities;

-number long-term beds for inpatient treatment;

-number of transitional or intermediate beds; and

-estimated total scheduled hours available for mental health services.

Data obtained from these sources were used to:

-Prioritize regions in terms of relative need for mental health services and

-assess present status of mental health delivery as discussed in Section III.

Based on review of results and planning committee discussions the ratio of mental health hours provided per 1,000 population was selected as best representing availability of resources for regional prioritization. Although, recommended in the guidelines (PL 94-63), it was determined that numbers of acute and long term beds would not represent a meaningful indication of available resources due to underutilization of present capacity, and were, therefore, not used to prioritize regions.

WEIGHTING

Assignment of weights to community mental health centers, private, public school and university mental health providers was based on the accessibility of service to residents and specific target groups. As a result higher weights were assigned to community mental health center and public school and university mental health providers as:

-community mental health center services are essentially available for all residents of the state.

-Public school and university systems are available to the youth irrespective of family income,

-while accessiblity of private practioners' services is limited by the ability to pay.

RANKING

As displayed in Exhibits A2, A3, and A4 individual rankings for each indicator were multiplied by the assigned weights and summed to determine final ranking.

PRIORITIZATION OF REGIONS

Final ranking of regional catchment areas based on socioeconomic, demographic, other social and health indicators, and estimated availability of mental health personnel hours is shown in Exhibit A1.

Individual rankings for each indicator were multiplied by the assigned weights and summed to determine regional prioritization.

NOTE: For a more detailed description of the methods used to determine regional prioritization for potential need for mental health services refer to the draft (2-17-76) Federal Guidelines for the Preparation of State Plans for Comprehensive Mental Health Services (PL 94-63) - Alcohol, Drug Abuse, and Mental Health Administration, National Institute of Mental Health - Division of Mental Health Programs. Copies of these guidelines are available at the State Department of Institutions, Bureau of Mental Health.

EXHIBIT A-1

	MENTAL HEALTH RESOURCES		OTHER SOCIAL AND HEALTH		SOCIOECONOMIC/ DEMOGRAPHIC		SCORE	FINAL RANKING
	SUMMARY SCORE	RANK	SUMMARY SCORE	RANK	SUMMARY SCORE	RANK		
REGION I	9	1	20	5	20	1	49	1
REGION II	19	5	13	3	26	2	56+	3
REGION III	18	4	11	2	37	4	56+	3
REGION IV	12	2	18	4	38	5	56+	3
REGION V	17	3	9	1	29	3	55	2

See footnotes on the last page of Appendix A

EXHIBIT A-2

RESOURCE SURVEY

ESTIMATED SCHEDULED WEEKLY HOURS PER 1000 POPULATION

REGIONS	COMMUNITY MENTAL HEALTH CENTERS			PRIVATE PRACTITIONERS			UNIVERSITY/ PUBLIC SCHOOL SYSTEM			SUMMARY SCORE	RANK	
	Rate	Rank	Wt	Rate	Rank	Wt	Rate	Rank	Wt			
I	7.9	3	2	0.4	1	1	-	1	2	9	1	
II	10.4	5	2	1.9	5	1	3.6	2	2	19	5	
III	8.6	4	2	1.5	2	1	5.2	4	2	18	4	
IV	4.2	1	2	1.8	4	1	3.8	3	2	12	2	
V	4.5	2	2	1.7	3	1	6.8	5	2	17	3	

See footnotes on the last page of Appendix A.

EXHIBIT A3

NEEDS SURVEY

SOCIAL AND HEALTH INDICATORS

REGIONS	MARRIAGE DISSOLUTIONS			INFANT MORTALITY			SUICIDE			MEDICAL ASSISTANCE RECIPIENTS			SUMMARY SCORE	RANK	SOCIOECONOMIC/ DEMOGRAPHIC SUMMARY SCORE	TOTAL SCORE	RANK
	Rate	Rank	Wt	Rate	Rank	Wt	Rate	Rank	Wt	Rate	Rank	Wt					
I	3.8	5	2	21.2	2	1	0.16	4	1	42.9	4	1	20	5	20	40	3
II	5.3	3	2	17.4	5	1	0.17	1	1	59.7	1	1	13	3	26	39	2
III	5.6	2	2	19.0	3	1	0.17	1	1	44.2	3	1	11	2	37	48	4
IV	4.9	4	2	22.6	1	1	0.16	4	1	41.7	5	1	18	4	38	56	5
V	6.6	1	2	18.9	4	1	0.17	1	1	47.9	2	1	9	1	29	38	1

See footnotes on the last page of Appendix A.

EXHIBIT A4

NEEDS SURVEY

SOCIOECONOMIC AND DEMOGRAPHIC INDICATORS

REGIONS	MALES IN LOW OCCUPATION STATUS			FAMILIES BELOW POVERTY LEVEL			YOUTH DEPENDENCY RATIO			AGED DEPENDENCY RATIO			HOUSEHOLDS WITH 1.01+ PERSONS PER ROOM			RECENT MOVERS (1969-70)			INDIAN POPULATION AS A % OF TOTAL COUNTY POPULATION			SUMMARY SCORE	RANK
	Rate	Rank	Wt	Rate	Rank	Wt	Rate	Rank	Wt	Rate	Rank	Wt	Rate	Rank	Wt	Rate	Rank	Wt	Rate	Rank	Wt		
I	30.8	5	1	15.1	1	1	76.5	1	2	19.8	1	2	21.7	1	1	23.7	5	1	6.9	2	2	20	1
II	31.5	3	1	14.1	3	1	74.1	2	2	15.7	5	2	21.1	2	1	28.6	2	1	7.0	1	2	26	2
III	31.3	4	1	14.3	2	1	67.9	4	2	17.5	4	2	17.1	5	1	25.6	4	1	3.8	3	2	37	4
IV	35.6	2	1	11.8	5	1	65.5	5	2	19.4	2	2	17.6	4	1	27.2	3	1	0.9	5	2	38	5
V	38.2	1	1	13.0	4	1	69.6	3	2	17.6	3	2	19.8	3	1	29.0	1	1	2.5	4	2	29	3

See footnotes on the last page of Appendix A.

FOOTNOTES TO EXHIBITS A 1 TO A 4

NEEDS SURVEY:	SOURCE
.SOCIOECONOMIC AND DEMOGRAPHIC INDICATORS - EXHIBITS A 4	
- Percent of males 16 years and over who are in low occupation status (1970)	
- Percent of families below poverty level (1970)	
- Youth dependency ratio i.e. persons under 18 years per 100 persons 18-64 yeara (1970)	
- Aged dependency ratio i.e. persons 65 and over per 100 persons 18-64 years (1970)	- U.S. Bureau of Census - 1970 Population and Housing Statistics
- Percent of household population in housing units with 1.01 or more persons per room(1970)	
- Percent of household population who moved into present residence 1960-1970, i.e. recent movers (1970)	
- Indian population as a percent of total county/region population (1970)	
.SOCIAL AND HEALTH INDICATORS EXHIBITS A	
- Marriage dissolutions, including divorces and annulments, per 1000 population. (1974)	- 1974 Montana Vital Statistics - Bureau of Records and Statistics
- Infant mortality ratio i.e. number of deaths under one year of age per 1000 live births (5 years 1970-1974)	- Bureau of Records and Statistics
- Suicide ratio i.e. number of suicides per 1000 population (1974)	- 1974 Montana Vital Statistics Bureau of Records and Statistics
- Welfare recipients i.e. recipients receiving medical assistance per 1000 population (1976)	- Montana Department of Social and Rehabilitative Services
.RESOURCE SURVEY EXHIBIT A 2	
- Scheduled hours per 1000 population (May 1976)	- Community Mental Health Centers
- Estimated scheduled hours per 1000 population (private practitioners) (May 1976)	- Community Mental Health Centers
- Estimated scheduled hours per 1000 population (1976)	- Superintendent of Public Instruction and Commission of Higher Education

APPENDIX B

NARRATIVE DESCRIPTION OF CATCHMENT AREAS

OVERVIEW

The development of community mental health services in Montana (population: 694,409 in '70 census) has been episodic in its growth. As an aftermath of World War II, mental hygiene clinics were started in 1948 as an outgrowth of the State Hospital and provided primarily outpatient care. In 1968, the first center was opened in Miles City but it was not until 1972 that the five basic services of inpatient, emergency, day treatment, outpatient and consultation/education were actually in effect in three catchment areas. By 1975 all five regions of the State were federally funded and providing the basic services making Montana the fifth state in the country to offer center services to the total population. However, these operations, minimally funded and having a huge geographic area to cover, were insufficient to appreciably effect the state hospital population. The growing disenchantment in the country to mental institutional care was evidenced in Montana in 1974-1975. A strike at Warm Springs State Hospital and Boulder River School and Hospital led to the National Guard being called in for six weeks and those returning citizens passed the word on the conditions existing in these institutions. The Ministerial Association produced a film "Them & Us" graphically portraying the plight of the institutionalized mentally ill and retarded. On the national level federal judges were taking action through court decisions to liberalize some of the outmoded customs governing the institutions with a strong emphasis on Civil Rights. The 1974 Montana Legislature passed Senate Bill 377 (R.C.M. 1947, Chapter 13), the Commitment Bill, to take effect July, 1975 which was a major step in

restoring civil rights to the institutionalized mentally ill, mandated improvements in care and custody, set up procedures for screening and aftercare and gave greatly increased thrust to community care. A new director of the Department of Institutions was hired in August, 1975 and in December, 1975 a major contract was signed with the five centers and Warm Springs State Hospital whereby funds were diverted from the hospital for greatly expanded screening and aftercare efforts in the community as mandated in R.C.M. 1947, Chapter 13.

The population at Warm Springs State Hospital reached 1,600 at its height in 1961, slowly descended to 903 by July, 1975 and to 480 by June 1, 1977. Obviously, a lot has happened in 1976-1977. The pace has quickened and the demand for community alternatives to institutionalization has increased. However, the mental health centers and the local communities are insufficiently equipped for these new demands. Community alternatives are not extensive and must be adequately developed. As of June 1977 only 14 transitional care facilities for the mentally ill existed in Montana. Sheltered workshops, group homes, foster homes are all in short supply. Community attitudes are untested.

The Department of Institutions sees the regional approach as the logical and most beneficial approach to developing adequate community alternatives. A county or city method of delivery of services would be too diffuse and haphazard. There already exists the nuclei of a regional approach in the existing five mental health centers. However, to expand and increase the scope of these regional centers will be a monumental task, one requiring careful and considerate planning. A large scale increase in community alternatives to institutional care through close cooperation and coordination with existing agencies is required to meet

current goals and objectives.

REGIONAL DEVELOPMENT OF MENTAL HEALTH SERVICES

In 1965 the State Mental Health Program consisted of five mental hygiene clinics which provided limited outpatient services, and Warm Springs State Hospital for residents requiring inpatient psychiatric treatment. These mental hygiene clinics were located in Montana's five largest cities - Billings (Region III), Great Falls (Region II), Butte and Helena (Region IV), and Missoula (Region V).

Legislation was enacted in response to needs identified in Montana's first State Plan for Mental Health Services (June 30, 1965) which resulted in establishing Eastern Montana Regional Community Mental Health Center (Region I) in December 1967. The remaining four comprehensive community mental health centers were established in the following chronological order.

DATE ESTABLISHED	NAME	REGION	NO. OF COUNTIES IN CATCHMENT AREA
January 1, 1971	Western Montana Regional Community Mental Health Center	V	7
September 1, 1971	South Central Montana Regional Mental Health Center	III	11
August 1, 1974	Northcentral Montana Community Mental Health Center	II	9
November 1, 1974	Southwest Montana Regional Community Mental Health Center	IV	12

On August 24, 1971 a Governor's Executive Order established 12 multi-county districts for use in planning and administration. This was amended on October 29, 1973 by Governor's Executive Order 7-73 which directed all state agencies that could most productively serve the state with fewer than 12 districts to adopt the following five administrative regions as displayed in Exhibit A 5.

Region I	Districts 1, 2, and 3
Region II	Districts 4 and 5
Region III	Districts 6 and 7
Region IV	Districts 8, 9, and 12
Region V	Districts 10 and 11

On pp. 36-39 (Section III) there is provided a broad perspective of the State's current mental health delivery system with the extent of population within regions having relative access to existing mental health programs (i.e. population for counties in which facilities for specific services are located divided by the total regional population). As indicated by this section the State currently falls short in meeting state and federal goals and objectives to provide uniform and accessible comprehensive mental health services to all residents, and minimize inappropriate institutionalization. Further, this section provided a basis for prioritizing the relative need for specific services required to meet these goals as follows:

.Transitional services.

.Specialized services for Indians, children and elderly.

.Partial hospitalization.

.Specialized services for drug and alcohol abuse.

.Emergency care.

.Outpatient, aftercare, screening and evaluation, and consultation and education.

In addition, exhibits are presented below for each catchment area to assist Regional Community Mental Health Boards in planning for additional programs and location of facilities.

For example in Region I, Roosevelt County is ranked as having the highest relative need for mental health services while only six of twelve services are provided in the county.

As displayed in Exhibit A6, Montana's seven Indian reservations are located in the following catchment areas:

Region I - Fort Peck
North Cheyenne

Region II - Rocky Boy
Blackfeet

Region III - Crow

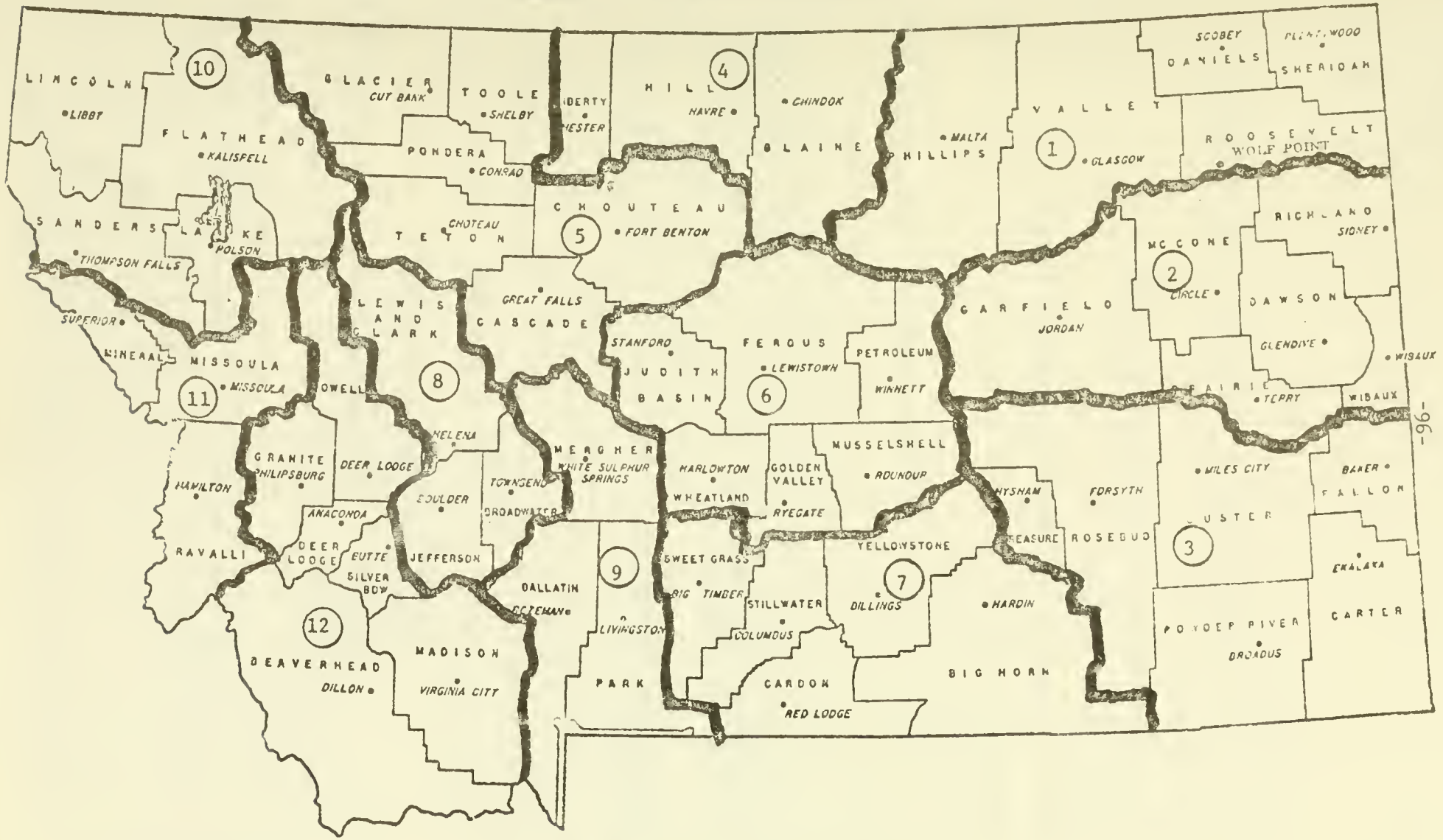
Region V - Flathead

The remaining reservation, Fort Belknap overlaps regional boundaries, portions are located in both Region I and II.

Exhibit A7, delineates the regional boundaries and identifies the location of mental health centers and satellites.

EXHIBIT A-5

MONTANA MULTI-COUNTY DISTRICTS



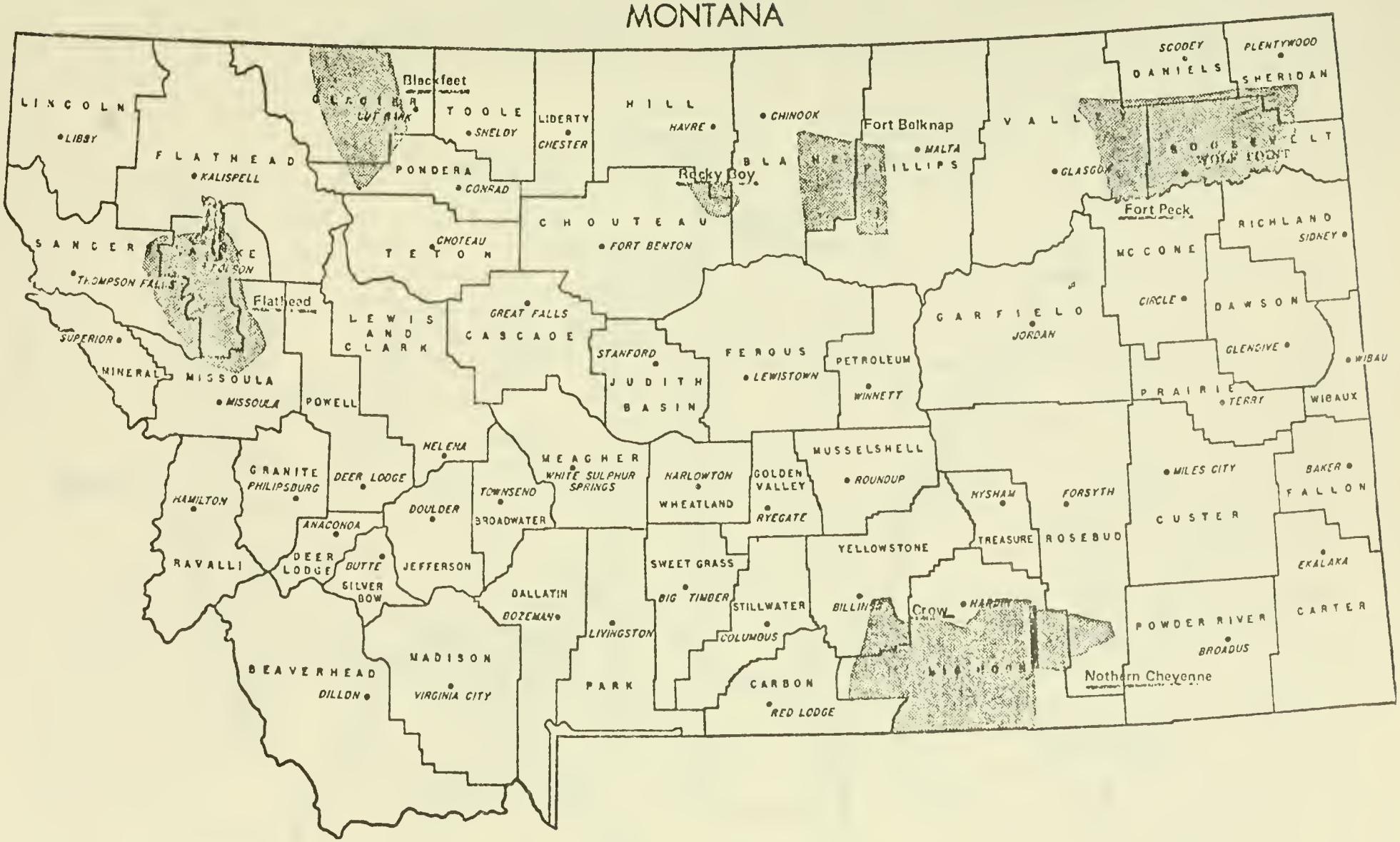
No. 1052 — County Outline Map

STATE PUBLISHING COMPANY

Helena

INDIAN RESERVATIONS

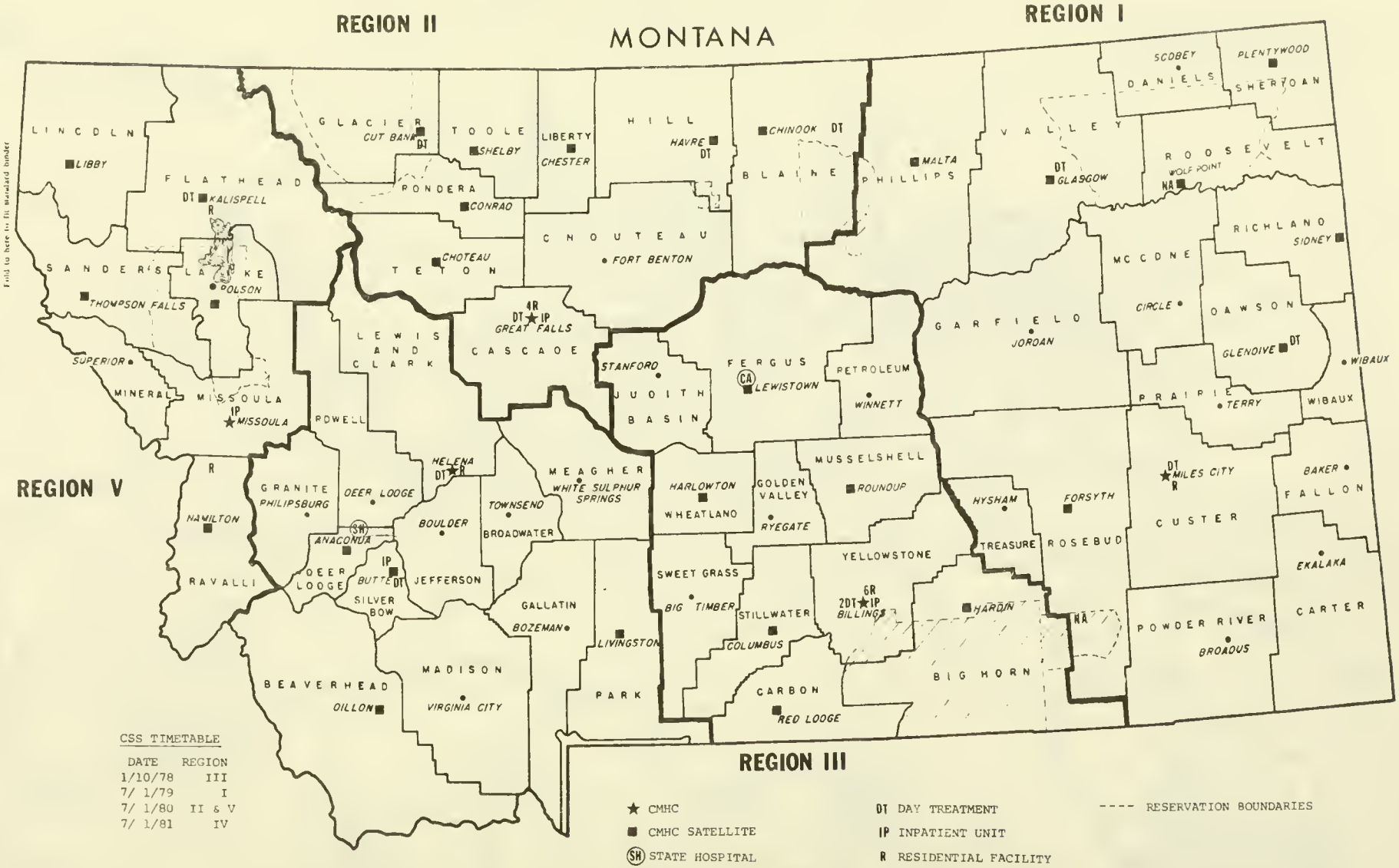
MONTANA



No. 1052 — County Outline Map

STATE PUBLISHING COMPANY
Helena

MENTAL HEALTH SYSTEM (as of 3/1/79)



CSS TIMETABLE

DATE	REGION
1/10/78	III
7/ 1/79	I
7/ 1/80	II & V
7/ 1/81	IV

★ CMHC
■ CMHC SATELLITE
(SH) STATE HOSPITAL
(CA) CENTER FOR THE AGED

DT DAY TREATMENT
IP INPATIENT UNIT
R RESIDENTIAL FACILITY
NA NATIVE AMERICAN OUTREACH WORKER

---- RESERVATION BOUNDARIES

DEMOGRAPHIC

The Eastern Montana Mental Health Region which consists of 17 counties, encompasses one third of the State and lies entirely within the Second U.S. Congressional District. The catchment area is bordered on the north by Canada; on the east by North and South Dakota; on the south by Wyoming; and on the west by Regions II and III.

The program's central facility and administrative headquarters are located in Miles City, Montana's tenth largest city. 1970 population - 9,023 (Source: U.S. Bureau of Census, 1970 Population and Housing Statistics). Exhibit A7 identifies the geographic location of the center's satellites and facilities.

COUNTIES AND POPULATION OF CATCHMENT AREA

COUNTIES	(1974 EST.)1 TOTAL POPULATION	COUNTIES	(1974 EST.)1 TOTAL POPULATION
Carter	1,900	Prairie	1,900
Custer	12,300	Richland	9,900
Daniels	3,200	Roosevelt	10,500
Dawson	10,900	Rosebud	7,700
Fallon	3,900	Sheridan	5,300
Garfield	1,600	Treasure	1,200
McCone	2,700	Valley	13,000
Phillips	5,500	Wibaux	1,400
Powder River	2,200		
		TOTAL	95,100

1 Source: Montana State Department of Health and Environmental Sciences, Bureau of Records and Statistics, 1974 Montana Vital Statistics.

SPECIAL CHARACTERISTICS

The region's catchment area comprises a 47,852 square mile area which is essentially rural and sparsely populated. In addition to overcoming physcial distances to provide mental health services, travel is hampered in the winter months by sub-zero temperatures and heavy snowfalls.

SERVICES

The region's mental health delivery system and current staffing patterns are presented in Exhibits A8 and A9 respectively.

EXHIBIT A-8

AREA MENTAL HEALTH RESOURCES SURVEY

REGION I

NAME AND LOCATION OF RESOURCE	OWNERSHIP OF FACILITY	BEDS			MENTAL HEALTH PERSONNEL WEEKLY HOURS			
		INPATIENT TREATMENT		TRANSITIONAL OR INTERMEDIATE	COMMUNITY MENTAL HEALTH CENTER	PRIVATE PRACTITIONERS	UNIVERSITY AND PUBLIC SCHOOL SYSTEMS	PHS INDIAN HEALTH SERVICES
		ACUTE	LONG-TERM					
EASTERN MONTANA REGIONAL MENTAL HEALTH CENTER MILES CITY	PRIVATE NON-PROFIT	[1]	90 [2]		348	-	-	-
CENTER SATELLITE ASHLAND	PRIVATE NON-PROFIT				44	-	-	-
CENTER SATELLITE FORSYTH	PRIVATE NON-PROFIT				40	-	-	-
CENTER SATELLITE GLASGOW	PRIVATE NON-PROFIT				160	-	-	-
CENTER SATELLITE PLENTYWOOD	PRIVATE NON-PROFIT				40	-	-	-
CENTER SATELLITE GLENDIVE	PRIVATE NON-PROFIT				80	-	-	-
PHS INDIAN HEALTH CENTER POPLAR	FEDERAL/ OTHER				-	-	-	160 [3]
PHS INDIAN HEALTH CENTER LAME DEER	FEDERAL/ OTHER				-	-	-	120
PSYCHOLOGIST	PRIVATE PRACTICE				-	36	-	-

1 Generally inpatient bed capacity is underutilized - accordingly beds are available on an as needed basis.
2 90 beds at Warm Springs State Hospital are assigned to the total Region.
3 Includes a Regional Community Mental Health Center employer - Mental Health Worker.

EXHIBIT A-9

COMMUNITY MENTAL HEALTH CENTER PROFESSIONAL STAFFING PATTERNS

REGION I

LOCATION		PSYCHIATRISTS		PSYCHOLOGISTS		PSYCHIATRIC NURSES		PSYCHIATRIC SOCIAL WORKERS		MENTAL HEALTH WORKERS		OTHER MENTAL HEALTH WORKERS		OCCUPATIONAL THERAPISTS		TOTAL	
COUNTY	CITY	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE
CUSTER	MILES CITY	1	1	2	2	3	2.5	1	1	-	-	2	2	1	0.2	10	8.7
ROSEBUD	ASHLAND	-	-	1	0.1	-	-	1	1	-	-	-	-	-	-	2	1.1
ROSEBUD	FORSYTH	-	-	1	1	-	-	-	-	-	-	-	-	-	-	1	1
VALLEY	GLASGOW	1	1	2	2	-	-	1	1	-	-	-	-	-	-	4	4
SHERIDAN	PLENTYWOOD	-	-	1	1	-	-	-	-	-	-	-	-	-	-	1	1
DAWSON	GLENDIVE	-	-	2	2	-	-	-	-	-	-	-	-	-	-	2	2
ROOSEVELT	POPLAR	-	-	-	-	-	-	-	-	-	-	1*	1*	-	-	1	1
TOTAL		2	2	9	8.1	3	2.5	3	3	-	-	3	3	1	0.2	21	18.8
TOTAL WEEKLY SCHEDULED HOURS		-	80	-	324	-	100	-	120	-	-		120		8		752

* Provides services at the Indian Public Health Service - Fort Peck Reservation.

DEMOGRAPHIC

The Northcentral Montana Mental Health Region consists of a total of nine counties. Of these counties Glacier, Toole, Liberty, and Pondera are within the First U.S. Congressional District, while the remaining five counties fall within the Second or Eastern U.S. Congressional District. Region II is bordered on the north by Canada; to the east by Region I; on the east by Regions III and IV; and to the west by Region V.

The program's central facility and administrative headquarters are located in Great Falls, Montana's second largest city - 1970 population - 60,091 (Source: U.S. Bureau of Census, 1970 Population and Housing Statistics). Exhibit A7 identifies the geographic location of the center's satellites and facilities.

COUNTIES AND POPULATION OF CATCHMENT AREA

COUNTIES	(1974 EST.)[1] TOTAL POPULATION
Blaine	6,800
Cascade	84,300
Chouteau	6,400
Glacier	11,400
Hill	17,700
Liberty	2,300
Pondera	6,700
Teton	6,400
Toole	5,400
TOTAL	147,400

1 Source: Montana State Department of Health and Environmental Sciences, Bureau of Records and Statistics, 1974 Montana Vital Statistics.

SPECIAL CHARACTERISTICS

The region's catchment area is approximately half the size of Region I and comprises 24,082 square miles. While almost 50% of the region's population live in Great Falls and Havre the remainder of the region is rural and sparsely populated.

SERVICES

The region's mental health delivery system and current staffing patterns are presented in Exhibits A10 and A11 respectively.

EXHIBIT A-10

AREA MENTAL HEALTH RESOURCES SURVEY

REGION 11

NAME AND LOCATION OF RESOURCE	OWNERSHIP OF FACILITY	BEDS			MENTAL HEALTH PERSONNEL WEEKLY HOURS			
		INPATIENT TREATMENT		TRANSITIONAL OR INTERMEDIATE	COMMUNITY MENTAL HEALTH CENTER	PRIVATE PRACTITIONERS	UNIVERSITY AND PUBLIC SCHOOL SYSTEMS	PHS INDIAN HEALTH SERVICES
		ACUTE	LONG-TERM					
NORTH CENTRAL COMMUNITY MENTAL HEALTH CENTER GREAT FALLS	PRIVATE NON-PROFIT	[1]	115 [2]		1090	-	-	
CENTER SATELLITE HAVRE	PRIVATE NON-PROFIT				200	-	-	
CENTER SATELLITE CUT BANK	PRIVATE NON-PROFIT				80	-	-	
CENTER SATELLITE SHELBY	PRIVATE NON-PROFIT				80	-	-	
CENTER SATELLITE CONRAD	PRIVATE NON-PROFIT				40	-	-	
CENTER SATELLITE CHOTEAU	PRIVATE NON-PROFIT				40			
PHS INDIAN HOSPITAL BROWNING	FEDERAL/ OTHER							40
PHS INDIAN HOSPITAL HARLEM	FEDERAL/ OTHER							40
PHS INDIAN HEALTH CENTER BOX ELDER	FEDERAL/ OTHER							40
PSYCHIATRISTS (4)	PRIVATE PRACTICE					160 [3]		
PSYCHOLOGISTS (3)	PRIVATE PRACTICE					120		
PSYCHOLOGISTS (13.4)							536	

[1] Generally inpatient bed capacity is underutilized - accordingly the beds are available on an as needed basis.
[2] 115 beds at Warm Springs State Hospital are assigned to the total Region.
[3] Includes one Psychologist employed by the U.S. Air Force.

EXHIBIT A-11

COMMUNITY MENTAL HEALTH CENTER PROFESSIONAL STAFFING PATTERNS

REGION II

LOCATION		PSYCHIATRISTS		PSYCHOLOGISTS		PSYCHIATRIC NURSES		PSYCHIATRIC SOCIAL WORKERS		MENTAL HEALTH WORKERS		OTHER MENTAL HEALTH WORKERS		OCCUPATIONAL THERAPISTS		TOTAL	
COUNTY	CITY	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	TOTAL
CASCADE	GREAT FALLS	-	-	3	3	2	2	8	7.25	7	7	7	7	1	1	28	27.25
HILL	HAVRE	-	-	1	1	-	-	2	2	1	1	-	-	1	1	5	5
GLACIER	CUT BANK	-	-	1	1	-	-	1	1	-	-	-	-	-	-	2	2
TOOLE	SHELBY	-	-	1	1	1	1	-	-	-	-	-	-	-	-	2	2
PONDERA	CONRAD	-	-	1	1	-	-	-	-	-	-	-	-	-	-	1	1
TETON	CHOTEAU	-	-	1	1	-	-	-	-	-	-	-	-	-	-	1	1
TOTAL		-	-	8	8	3	3	11	10.25	8	8	7	7	2	2	39	38.25
TOTAL WEEKLY SCHEDULED HOURS		-	-	-	320		120	-	410		320		280		80		1530

DEMOGRAPHIC

The Southcentral Mental Health Region consists of eleven counties and is entirely within the Second U.S. Congressional District. The catchment area is bordered on the north by Regions I and II; to the east by Region I; the south by the State of Wyoming; and the west by Region IV.

The program's central facility and administrative headquarters are located in Billings, Montana's largest city. Exhibit A7 identifies the geographic location of the center's satellites and facilities.

COUNTIES AND POPULATION OF CATCHMENT AREA

COUNTIES	(1974 EST.)[1] TOTAL POPULATION
Big Horn	10,500
Carbon	7,900
Fergus	12,900
Golden Valley	900
Judith Basin	2,700
Musselshell	4,200
Petroleum	600
Stillwater	5,200
Sweet Grass	3,100
Wheatland	2,500
Yellowstone	94,300
TOTAL	144,800

1 Sources: Montana State Department of Health and Environmental Sciences, Bureau of Records and Statistics, 1974 Montana Vital Statistics.

SPECIAL CHARACTERISTICS

While approximately 65% of the region's total population are located

in Yellowstone the remaining ten counties are rural and sparsely populated. The region's catchment area comprises a 25,625 square mile area in which agriculture is the dominent industry.

SERVICES

The region's mental health delivery system and current staffing patterns are presented in Exhibits A12 and A13 respectively.

EXHIBIT A-12

AREA MENTAL HEALTH RESOURCES SURVEY

REGION III

NAME AND LOCATION OF RESOURCE	OWNERSHIP OF FACILITY	BEDS			MENTAL HEALTH PERSONNEL WEEKLY HOURS			
		INPATIENT TREATMENT		TRANSITIONAL OR INTERMEDIATE	COMMUNITY MENTAL HEALTH CENTERS	PRIVATE PRACTITIONERS	UNIVERSITY AND PUBLIC SCHOOL SYSTEMS	PHS INDIAN HEALTH SERVICES
		ACUTE	LONG-TERM					
SOUTH CENTRAL MONTANA REGIONAL COMMUNITY MENTAL HEALTH CENTER BILLINGS	PRIVATE NON-PROFIT	[1]	[2] 115	8	852			
CENTER SATELLITE COLUMBUS	PRIVATE NON-PROFIT				40			
CENTER SATELLITE HARDIN	PRIVATE NON-PROFIT				120			
CENTER SATELLITE RED LODGE	PRIVATE NON-PROFIT				40			
CENTER SATELLITE ROUNDUP	PRIVATE NON-PROFIT				40			
CENTER SATELLITE HELENA	PRIVATE NON-PROFIT				40			
CENTER SATELLITE LEWISTOWN	PRIVATE NON-PROFIT				80			
PSYCHIATRISTS (4)	PRIVATE PRACTICE					160		
PSYCHOLOGISTS (1)	PRIVATE PRACTICE					40		
PSYCHIATRIC SOCIAL WORKER (0.5)	PRIVATE PRACTICE					20		
PSYCHOLOGISTS (16)							640	
MENTAL HEALTH PROFESSIONALS (3)							120	

[1] Generally inpatient bed capacity is underutilized - accordingly beds are available on an as needed basis.
[2] 115 beds at Warm Springs State Hospital are assigned to the total Region.

EXHIBIT A-13

COMMUNITY MENTAL HEALTH CENTER PROFESSIONAL STAFFING PATTERNS

REGION III

LOCATION		PSYCHIATRISTS		PSYCHOLOGISTS		PSYCHIATRIC NURSES		PSYCHIATRIC SOCIAL WORKERS		MENTAL HEALTH WORKERS		OTHER MENTAL HEALTH WORKERS		OCCUPATIONAL THERAPISTS		TOTAL	
COUNTY	CITY	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	TOTAL
YELLOW-STONE	BILLINGS	3	0.3	4	4	2	1.5	5	4.5	9	9	1	1	1	1	25	21.3
STILL-WATER	COLUMBUS	-	-	1	1	-	-	-	-	-	-	-	-	-	-	1	1
BIG HORN	HARDIN	-	-	1	1	-	-	1	1	1	1	-	-	-	-	3	3
CARBON	RED LODGE	-	-	1	1	-	-	-	-	-	-	-	-	-	-	1	1
MUSSEL-SHELL	ROUNDUP	-	-	1	1	-	-	-	-	-	-	-	-	-	-	1	1
WHEAT-LAND	HARLOWTON	-	-	1	1	-	-	-	-	-	-	-	-	-	-	1	1
FERGUS	LEWISTOWN	-	-	1	1	1	1	-	-	-	-	-	-	-	-	2	2
TOTAL		3	0.3	10	10	3	2.5	6	5.5	10	10	1	1	1	1	34	30.3
TOTAL WEEKLY SCHEDULED HOURS		-	12	-	400	-	100	-	220		400	-	40	-	40		* 1252

* Includes 1 full-time teacher in the Children's Day Care Program in Yellowstone.

DEMOGRAPHIC

The Southwest Montana Mental Health Region consists of twelve counties and lies within the First U.S. Congressional District. It is the most urbanized of Montana's five mental health regions, and contains four of the state's ten largest cities - Anaconda, Bozeman, Butte and Helena. The catchment area is bordered on the north by Region II; to the east by Region III; south by Yellowstone National Park (Wyoming) and by the State of Idaho; and to the west by Region V and Idaho State.

The program's central facility and administrative headquarters are located in Helena. Exhibit A7 identifies the geographic location of the center's four satellites and facilities.

COUNTIES AND POPULATION OF CATCHMENT AREA

COUNTIES	(1974 EST.)[1] TOTAL POPULATION
Beaverhead	8,300
Broadwater	2,700
Deer Lodge	15,100
Gallatin	36,000
Granite	2,700
Jefferson	6,900
Lewis and Clark	36,000
Madison	5,900
Meagher	2,100
Park	11,900
Powell	7,400
Silver Bow	43,200
TOTAL	178,200

1 Sources: Montana State Department of Health and Environmental Sciences, Bureau of Records and Statistics, 1974 Montana Vital Statistics.

SPECIAL CHARACTERISTICS

The 28,690 square miles of Region IV's catchment area can be described as semi-arid and mountainous. Since counties of the Region lie both to the east and to the west of the Continental Divide, travel is often circuitous. It may be necessary to travel 150 miles to cover an air distance of 25 miles. Mountain passes between Butte and Helena and between Butte and Bozeman make winter travel hazardous. Smaller mountain passes in other parts of the catchment area have similar effects on winter travel which often is completely halted by weather and road conditions.

The urban population of the region is concentrated in Deer Lodge, Gallatin, Lewis and Clark, and Silver Bow Counties. Smelting and mining are the major industries in Deer Lodge County (Anaconda) and Silver Bow County (Butte). Bozeman, in Gallatin County, is the seat of Montana State University and the State Capitol is located at Helena in Lewis and Clark County. The State's only psychiatric hospital is located at Warm Springs in Powell County and other state institutions such as the State Prison, Boulder River School and Hospital, and Galen State Hospital, an Alcoholic Treatment Center are located within the catchment area. The counties of Beaverhead, Broadwater, Granite, Jefferson, Madison, Meagher, Powell, and Park are essentially rural and sparsely populated.

SERVICES

The region's mental health delivery system and current staffing patterns are presented in Exhibits A14 and A15 respectively.

EXHIBIT A-14

AREA MENTAL HEALTH RESOURCES SURVEY

REGION IV

NAME AND LOCATION OF RESOURCE	OWNERSHIP OF FACILITY	Beds			MENTAL HEALTH PERSONNEL WEEKLY HOURS			
		INPATIENT TREATMENT		TRANSITIONAL OR INTERMEDIATE	COMMUNITY MENTAL HEALTH CENTER	PRIVATE PRACTITIONERS	UNIVERSITY AND PUBLIC SCHOOL SYSTEMS	PHS INDIAN HEALTH SERVICES
		ACUTE	LONG-TERM					
SOUTHWEST MONTANA REGIONAL COMMUNITY MENTAL HEALTH CENTER HELENA	PRIVATE NON-PROFIT	[1]	[2]		220			
CENTER SATELLITE BUTTE	PRIVATE NON-PROFIT		242		320			
CENTER SATELLITE ANACONDA	PRIVATE NON-PROFIT				30			
CENTER SATELLITE DILLON	PRIVATE NON-PROFIT				40			
CENTER SATELLITE LIVINGSTON	PRIVATE NON-PROFIT				80			
PSYCHOLOGISTS (8)	PRIVATE PRACTICE					320		
PSYCHIATRIST (1)							40	
PSYCHOLOGISTS (16)							640	

[1] Generally inpatient bed capacity is underutilized - accordingly beds are available on an as needed basis.
[2] 242 beds at Warm Springs State Hospital are assigned to the total Region.

EXHIBIT A-15

COMMUNITY MENTAL HEALTH CENTER PROFESSIONAL STAFFING PATTERNS

REGION IV

LOCATION		PSYCHIATRISTS		PSYCHOLOGISTS		PSYCHIATRIC NURSES		PSYCHIATRIC SOCIAL WORKERS		MENTAL HEALTH WORKERS		OTHER MENTAL HEALTH WORKERS		OCCUPATIONAL THERAPISTS		TOTAL	
COUNTY	CITY	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	TOTAL
SILVER BOW	BUTTE	1	1	2	2	2	2	-	-	2	2	1	1	-	-	8	8
LEWIS & CLARK	HELENA	1	1	2	2	2	2	-	-	-	-	-	-	1	0.5	6	5.5
DEER LODGE	ANACONDA	-	-	2	2	-	-	-	-	-	-	-	-	-	-	2	2
BEAVER-HEAD	DILLON	-	-	1	1	-	-	-	-	-	-	-	-	-	-	1	1
PARK	LIVINGSTON	-	-	1	1	1	1	-	-	-	-	-	-	-	-	2	2
TOTAL		2	2	8	8	5	5	-	-	2	2	1	1	1	0.5	19	18.5
TOTAL WEEKLY SCHEDULED HOURS		-	80	-	320	-	200	-	-	-	80	-	40	-	20	-	740

DEMOGRAPHIC

The Western Montana Mental Health Region consists of seven counties and lies within the First U.S. Congressional District. The catchment area is bordered on the north by Canada; to the east by Glacier National Park and portions of Regions II and IV; to the south and west by the State of Idaho.

The program's central facility and administrative headquarters are located in Missoula, Montana's third largest city. Exhibit A7 identifies the geographic location of the Center's five satellites and facilities.

COUNTIES AND POPULATION OF CATCHMENT AREA

COUNTIES COUNTIES	(1974 EST.)[1] TOTAL POPULATION
Flathead	42,600
Lake	16,700
Lincoln	17,000
Mineral	3,600
Missoula	63,700
Ravalli	17,900
Sanders	7,800
TOTAL	169,300

1 Sources: Montana State Department of Health and Environmental Sciences, Bureau of Records and Statistics, 1974 Montana Vital Statistics.

SPECIAL CHARACTERISTICS

The 19,339 square miles of Region V's catchment area lie within the Rocky Mountains. The terrain is rugged, heavily forested, and with numerous basins and valleys, rivers and lakes. The population of the

catchment area is concentrated in the valleys. The University of Montana which has a student enrollment of more than 7,500 is located in Missoula, the largest trade and service center for the catchment area. With the exception of Kalispell in Flathead County all other communities in the region have populations of less than 3,000.

SERVICES

The region's mental health delivery system and current staffing patterns are presented in Exhibits A16 and A17 respectively.

EXHIBIT A-16

AREA MENTAL HEALTH RESOURCES SURVEY

REGION V

NAME AND LOCATION OF FACILITY	OWNERSHIP OF FACILITY	BEDS			MENTAL HEALTH PERSONNEL WEEKLY HOURS			
		INPATIENT TREATMENT		TRANSITIONAL OR INTERMEDIATE	COMMUNITY MENTAL HEALTH CENTER	PRIVATE PRACTITIONERS	UNIVERSITY AND PUBLIC SCHOOL SYSTEMS	PHS INDIAN HEALTH SERVICES
		ACUTE	LONG-TERM					
WESTERN MONTANA REGIONAL COMMUNITY MENTAL HEALTH CENTER MISSOULA	PRIVATE NON-PROFIT	[1]	[2] 118	4	400			
CENTER SATELLITE KALISPELL	PRIVATE NON-PROFIT				200			
CENTER SATELLITE RONAN	PRIVATE NON-PROFIT				40			
CENTER SATELLITE LIBBY	PRIVATE NON-PROFIT				40			
CENTER SATELLITE THOMPSON FALLS	PRIVATE NON-PROFIT				20			
CENTER SATELLITE HAMILTON	PRIVATE NON-PROFIT				60			
PSYCHIATRISTS (3)	PRIVATE PRACTICE					120		
PSYCHOLOGISTS (4)	PRIVATE PRACTICE					160		
PSYCHIATRISTS (1)							40	
PSYCHOLOGISTS (24.9)							996	
OTHER (2)							80	
PHS INDIAN HEALTH CENTER ST. IGNATIUS	FEDERAL/ OTHER							40

[1] Generally Inpatient bed capacity is underutilized - accordingly beds are available on an as needed basis.
[2] 118 beds at Warm Springs State Hospital are assigned to the total Region.

EXHIBIT A-17

COMMUNITY MENTAL HEALTH CENTER PROFESSIONAL STAFFING PATTERNS

REGION V

LOCATION		PSYCHIATRISTS		PSYCHOLOGISTS		PSYCHIATRIC NURSES		PSYCHIATRIC SOCIAL WORKERS		MENTAL HEALTH WORKERS		OTHER MENTAL HEALTH WORKERS		OCCUPATIONAL THERAPISTS		TOTAL	
AREA	CITY	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	FTE	NUMBER	TOTAL
MISSOULA	MISSOULA	1	1	3	3	-	-	3	3	2	1.5	4 *	1.5 *	-	-	13	10
FLATHEAD	KALISPELL	1	1	2	2	-	-	1	1	1	1	-	-	-	-	5	5
LAKE	RONAN	-	-	1	1	-	-	-	-	-	-	-	-	-	-	1	1
LINCOLN	LIBBY	-	-	1	1	-	-	-	-	-	-	-	-	-	-	1	1
SANDERS	THOMPSON FALLS	-	-	-	-	-	-	-	-	1	0.5	-	-	-	-	1	0.5
RAVALLI	HAMILTON	-	-	-	-	-	-	1	1	1	0.5	-	-	-	-	2	1.5
TOTAL		2	2	7	7	-	-	5	5	5	3.5	4	1.5	-	-	23	19
TOTAL WEEKLY SCHEDULED HOURS		-	80	-	280	-	-	-	200	-	140	-	60	-	-	-	760

* Four Doctorate Candidates fulfilling practicum requirements

STANDARDS FOR COMMUNITY MENTAL HEALTH CENTERS

I. INTRODUCTION

The "Standards for Community Mental Health Centers" March 21, 1974, is hereby rendered obsolete and is replaced by the following Standards:

PREFACE

As the major locus of service delivery in Montana shifts from the single multipurpose state institution to more diversified, locally based and community oriented service components, the state's obligation for coordination, monitoring, and funding becomes increasingly complex. The accompanying Standards serve to reflect both the specific mandates of Federal and Montana State law as well as the more intangible aspects of treatment delivery that we believe to be in concert with the present state-of-the-art.

Development of these revised Standards was the joint effort of a committee composed of staff from the Mental Health and Residential Services Division, Regional Mental Health Center Board Chairmen or their delegated representative, and Directors from the five Regional Mental Health Centers. Existing standards from the State of Montana as well as community mental health standards from the states of Colorado, Michigan, New York, Utah and Wyoming were reviewed. Where applicable existing standards were found, they were incorporated in the present document. Necessarily, the final authority and responsibility for implementation of the Standards is vested in the Director, Department of Institutions. A permanent study committee has been established under the auspices of the Mental Health and Residential Services Division to periodically review the Standards to insure their continued applicability. Additionally, comments from all concerned parties,

including service recipients, will be solicited and where appropriate incorporated in revisions of the Standards. As national standards of performance are developed and are found to be appropriate to Montana's mental health system, accreditation through a national organization would meet the Department's requirements for assurance of a minimum level of performance.

Finally, it is recognized that treatment of the mentally ill is still in the embryonic stage of development and we have not yet achieved a level of sophistication that identifies a single modality as The Way. Consequently, full compliance with the standards as they are presently written is viewed as an ideal goal to be sought over a reasonable period of time. Thus efforts have been made to allow maximum flexibility to each center in meeting the particular mental health problems indigenous to their community, while concommitantly establishing uniform minimum standards for operation and maintenance.

Legal Authority

The Community Mental Health Center Act of 1963 as amended in 1975, stipulates that those states receiving federal funds for establishment of Comprehensive Mental Health Centers must include in their State Plan of Mental Health Services provision for the establishment and enforcement of Standards of maintenance and operation of community mental health centers:

> "provide minimum standards (to be fixed in the discretion of the State) for the maintenance and operation of centers which receive Federal aid under this title and provide for enforcement of such standards with respect to projects approved by the Secretary under this title:. [1]

Responsibility to establish and enforce such standards was delegated to the Department of Institutions by the Montana State Legislature, and are thus promulgated with the full sanction and authority of the legislature. [2]

The enforcement of community mental health standards can be accomplished most effectively through periodic review of the program. Reviews shall be conducted either separately or jointly by Federal and State consultants including site visits to review the services, records and premises of a center.

The Department of Institutions' authority or his representative shall conduct at least annual reviews of each center program. Additional reviews may be scheduled during the year. Centers found not conforming to the Standards and program plan may be placed on six-month probation period. Should satisfactory progress not be made in the judgment of the Department of Institutions, State funds may be withheld. Center may appeal decision to the Board of Institutions.

[1] Section 237, a(2,E), P.L. 94063
[2] R.C.M. 1947, Chapter 15 80-2802 (8)

ORGANIZATION/OPERATIONS

Under existing Montana law, the Regional Community Mental Health Boards have ultimate responsibility for provision of mental health services within their designated catchment areas. Although generally delegating performance of the day-to-day functions of program implementation, fiscal management and service planning, to be effective the Board must maintain an active and informed role in the overall operations of its center. In fact, the degree to which the Board is involved with the various components of its center's programs will bear directly on the effectiveness of the organization's functioning.

As a legally established corporate body, the Board must comply with and fulfill requirements described in such documents as The Nonprofit Corporation Act, Chapter 28 R.C.M. 1947, and the CMHC STANDARDS. In order to effectively discharge its responsibilities, the Board should establish by-laws and operating procedures which include organizing specific decision-making responsibilities, defining channels of communication, establishing effective committee assignments and other such internal organizational structuring as necessary to optimally discharge its responsibilities.

Because effective decision-making is based on members' respective knowledge of mental health and related fields, the Board should plan and implement an orientation program for its members. Such a program should be an ongoing educational process designed to keep all members informed about the status of its programs as well as new trends in the area of mental health.

The Board should set policies to guide program operations and to protect the rights of its service recipients. It should monitor the implementation and maintenance of these policies to ensure that decisions at the program level are consonant with established Board policies. Finally, to achieve effective long-range planning and to facilitate its program monitoring capabilities, the Board should develop a system of measurable goals and objectives.

1.1 THE ESTABLISHMENT AND ORGANIZATION OF THE BOARD IS CONSISTENT WITH STATE AND FEDERAL REQUIREMENTS (All required) A

a) The Board is composed of members who are representatives of the residents of their region.

b) The Board shall meet such legal statures as required to receive and administer monies made available through grants from the Federal government, State government, and other agencies, fees for services rendered, tax monies, donations and other types of support or income for purposes of providing mental health services in their region.

c) The Board has established written by-laws.

d) The Board meets regularly, at least 12 times per year (this does not include committee meetings). P.L. 94-63, Sec. 201(E)

e) The Board has a defined number of officers and members that comprise quorum attendance.

f) Written minutes which document action taken by the Board are distributed to Board members, all programs affiliated with the Board, and to all appropriate agencies following each Board meeting.

g) The Board utilizes a committee structure to conduct the main body of work, and these committees report regularly to the Board.

h) Term of office

i) No conflict of interest

1.2 THE ADMINISTRATIVE ORGANIZATION OF THE BOARD PROMOTES EFFECTIVE OPERATION OF ITS VARIOUS PROGRAMS AND AGENCIES. (3 of 5 required) B

a) The Board has an up-to-date organizational chart which accounts for all its services.

b) Decision-making responsibilities within the organization are clearly defined and functioning.

c) Channels of communication within the organization are clearly defined and functioning.

d) The Board has developed an administrative manual that is up-to-date.

e) The Board has clearly defined and measurable short-term and long-term goals and objectives for all its mental health programs.

1.3 THE BOARD DELEGATES TO THE CENTER DIRECTOR RESPONSIBILITY AND AUTHORITY FOR IMPLEMENTATION OF ITS MENTAL HEALTH PROGRAMS. (All) A

a) The Board delegates policy implementation and daily operational functioning to its Center Director.

b) The responsibility and limitations of the Center Director are clearly defined.

c) The Board, through its Center Director, communicates policies to all who need to use them for decision-making.

1.4 THE BOARD HAS PROVISIONS FOR INSURING THE ORGANIZATION AGAINST A RANGE OF LIABILITIES. (All) A

The types of insurance a Board carries include the following:

a) Fidelity bonding of key employees (Director, Business Manager, etc.)

b) Professional liability insurance

c) Comprehensive fire and theft insurance

d) Workman's Compensation and/or personal injury insurance

1.5 THE BOARD HAS A PROVISION FOR MONITORING THE DECISIONS AND OPERATION OF ITS PROGRAMS TO ENSURE THAT THEY REMAIN WITHIN POLICY GUIDELINES. (All) B

a) The Board receives regular reports on program operations.

b) The Board receives regular reports on expenditures.

c) The Board has provision for periodic evaluation of its program relative to program goals.

1.6 THE BOARD PLANS AND IMPLEMENTS AN ORIENTATION AND CONTINUING EDUCATION PROGRAM FOR BOARD MEMBERS. B

This program includes information about topics such as: (5 of 9)

a) Current concepts of mental health

b) The history and current organization of Community Mental Health in Montana

c) Current methods of program evaluation

d) Confidentiality and clients' rights issues

e) The philosophy and techniques of a comprehensive Community Mental Health model.

f) The responsibility of Board membership

g) Information about sources of funds

h) The Community Mental Health Center Standards

i) The relationship of community mental health to other human services organizations.

1.7 THE BOARD HAS ESTABLISHED ADVISORY COUNCIL(s) TO ADVISE THE GOVERNING BOARD. (3 of 5) B

a) The Advisory Council(s) shall be representatives of the residents of the region.

b) At least one-half of the members of the Advisory Council(s) shall not be providers of health care.

c) At least one member of the Advisory Council shall be a member of any ethnic or cultural minority group indigenous to the region that comprise 10% or more of the total regional population.

d) Where practical, members of other health service agencies shall be solicited as Advisory Council members.

e) The Advisory Council should assist the Board with respect to patterns of utilization of sources, impact of services and needs assessment of the regions.

1.8 THE BOARD SEEKS OUT AND NEGOTIATES WITH GOVERNMENTAL AGENCIES AND OTHER POTENTIAL SOURCES OF FUNDS TO SECURE ADDITIONAL RESOURCES NEEDED TO IMPLEMENT THEIR PROGRAMS. (3 of 4) B

a) The Board has a clearly defined mechanism for seeking funds.

b) The Board is well-informed regarding potential funding sources. They have first hand knowledge (or immediate access to information) about the availability and limitation of funds from potential sources.

c) The Board maintains formal and/or informal contacts with potential funding sources.

d) The Board negotiates adjustments in program proposals when necessary to comply with funding source requests.

1.9 THE BOARD SIGNS WRITTEN CONTRACTUAL AGREEMENTS WITH AGENCIES WHO ARE RECEIVING COMMUNITY MENTAL HEALTH CENTER FUNDS FOR SERVICES PERFORMED. THESE CONTRACTS CLEARLY IDENTIFY THE RESPONSIBILITIES OF BOTH PARTIES. (All) A

a) A clear description of services to be performed and any limitations or exclusions.

b) The dates during which the contract is binding.

c) The amount of funds to be received by the contract agency and, when feasible, with unit costs or per diem rates.

d) A provision specifying responsibilities of the contract agency to provide the Board with such information as required to evaluate the contract effectiveness.

e) A provision for monitoring of the contract by both parties.

f) A provision which specifies the condition and procedure to be used by either party in terminating the contract.

PROGRAM PLANNING

The basic objective of a Community Mental Health Center Board is to plan and arrange for an array of comprehensive programs designed to ameliorate identified mental health needs. Such need identification should incorporate locally established priorities so that the resulting combination of services is oriented toward the specific and unique requirements of its catchment area. It is also vital that the services of the Center function as components of the larger human services system meeting clients' other needs. To develop such an array of relevant programming and to adequately integrate services in the community requires careful and thorough planning by the Mental Health Center Board.

Such planning is comprised of the following steps: 1) a description of the community to be served; 2) an assessment of mental health needs within the community; 3) a description of existing services and 4) a description of how existing and proposed services will meet the community's mental health needs.

A Budget Request should accompany each Service Plan and should include a detailed description of the projected costs of the program.

To avoid duplication, the Board must determine if existing services are adequate or could be expanded to meet identified needs, or if the Mental Health Center should provide the service. If the Board decides to utilize an existing service, both parties must sign an agreement which specifies in detail their mutual responsibilities. If the Board opts to provide the service through the Center, plans must be developed to recruit staff, allocate space, etc.

2.1 AT LEAST EVERY TWO YEARS, EACH COMMUNITY MENTAL HEALTH CENTER BOARD PREPARES A COMPREHENSIVE SERVICE PLAN WHICH IS SUBMITTED TO THE DEPARTMENT OF INSTITUTIONS IN ACCORDANCE WITH DEPARTMENTAL POLICY.

The Comprehensive Service Plan includes the following components: (ALL)

a) A description of the community to be served including pertinent demographic information, geographic description, economic data, and estimates of the types and extent of significant social and health problems which relate to mental health services.

b) Estimates of the types and extent of mental health related problems including social indicator data, characteristics of case loads of the Community Mental Health Center and general observation of other health service agency activities.

c) A description of existing services dealing with the estimated mental health-related problems including an evaluation of the degree to which the services match estimated needs.

d) A projection of the amount and type of mental health services needed to adequately serve the comprehensive mental health needs of the client population.

e) A description of how existing and proposed mental health programs fit into the long-range plans described in d above. This should include a priority structure of new programs and estimated dates of implementation.

2.2 AN ANNUAL BUDGET REQUEST IS SUBMITTED WITH THE COMPREHENSIVE SERVICES PLAN FOR EACH PROGRAM AND INCLUDES A DETAILED BREAKDOWN OF THE PROJECTED COSTS OF THE PROGRAM WITH UNIFORM LINE ITEM DETAILS IN ACCORDANCE WITH DEPARTMENTAL POLICY.

COMMUNITY INVOLVEMENT

For the comprehensive community mental health center concept to become an effective agency of the community, input from all sectors of the community is essential. Thus, if the Board is to successfully facilitate the delivery of needed mental health services to the community, it is necessary that the Board involve itself with all levels of the community throughout all phases of program development and implementation.

Further, input and exchange of information between the Board, consumer and citizen groups, other human service agencies and others can greatly enhance a Board's ability to make informed, appropriate decisions regarding programs. Such community participation and input as well as an open receptive attitude towards criticism regarding development of service can enhance community receptivity to Center service and often prevent serious mistakes.

Public information concerning existing Center programs and proposed changes will also contribute to the general public awareness and utilization of services. Such a program would include not only public speaking engagements, but also use of the public media, distribution of written information, and ensuring that each program funded by the Board is identified as part of Community Mental Health.

3.1 THE COMMUNITY MENTAL HEALTH BOARD PARTICIPATES IN THE PLANNING OF A RANGE OF HEALTH AND SOCIAL SERVICES WITHIN ITS GEOGRAPHIC BOUNDARIES. (2 of 3) B

a) The Board is aware of and actively involved with regional agencies or councils responsible for health service planning.

b) The Board is actively involved with local school districts.

c) The Board is actively involved with regional interagency coordinating committees.

3.2 THE BOARD HAS PROVISION FOR SOLICITING RECOMMENDATION AND COMMENTS FROM PERTINENT MEMBERS OF THE COMMUNITY REGARDING THE PLANNING AND DEVELOPMENT OF MENTAL HEALTH PROGRAMS. B

These include: (3 of 4)

a) Provision for making special invitations to interested groups and interested citizens to attend Board meetings or committee meetings.

b) Provision for soliciting input from staff or contract agencies.

c) Provision for soliciting input from groups of people related to or affected by an issue under consideration.

d) Provision for conducting an annual public meeting on the Financial and Program Plan.

3.3 THE BOARD OPERATES AN EFFECTIVE PUBLIC INFORMATION PROGRAM TO FACILITATE AWARENESS OF ITS MENTAL HEALTH PROGRAMS. (2 of 3) B

a) The Board distributes written information on its mental health services to the community-at-large.

b) The Board uses a range of media for presenting mental health information (newspapers, radio, television, etc.)

c) The Board is available for speaking engagements at various organizations in the community.

3.4 THE BOARD ENSURES THAT ITS PROGRAMS AND CONTRACTED SERVICES ARE VISIBLE AS PART OF COMMUNITY MENTAL HEALTH SERVICES. (2 of 3) A

a) The board maintains a comprehensive listing of its services in appropriate telephone directories.

b) The Board's public information materials list all programs and services where applicable.

c) Public information materials used by Board programs and contract agencies indicate their affiliation with the Board.

FISCAL MANAGEMENT

A major responsibility of the Board is to ensure accurate and appropriate disbursement of Board funds. In part because the Board is a public non-profit organization supported by public funds, and in part as a result of the complexity of funding source and consequent accounting requirements, it is imperative that the Board adopt clear policies and procedures including written accounting procedures and purchasing policies.

Additionally, public accountability as well as sound fiscal management practices require that the Board provide regular and timely financial reports and perform periodic audits of all accounts.

4.1 THE BOARD ADOPTS CLEAR POLICIES AND PROCEDURES TO ENSURE THE EFFICIENT AND ACCURATE DISTRIBUTION OF FUNDS. (All required) A

a) There is a Board approved operating budget.

b) Written purchasing policies are followed. These policies require systematic approval by responsible staff for all expenditures for supplies, equipment and contracted service.

c) There is a written procedure for the inventory and control of equipment, etc., costing at least $100.00.

4.2 ALL DISBURSEMENTS OF THE BOARD'S FUNDS ARE RECORDED IN SUCH A MANNER AS TO CLEARLY SHOW TO WHICH BUDGET CATEGORY THEY ARE CHARGED. (ALL) A

a) Accounting records clearly show all financial transactions through a uniform accounting system including a single chart of accounts and accounting manual (HB 483)

b) The plan of expenditures corresponds to the current distribution of staff and other resources.

c) All changes in spending must be consistent with funding source guidelines or be made only with prior written approval from the funding source.

d) Regular and comprehensive financial reports are compiled for the Board and all funding sources.

e) The Board has its financial records audited annually by either public or private auditors.

4.3 THE BOARD HAS CLEARLY DEFINED MECHANISMS FOR THE COLLECTION OF FEES FROM CLIENTS AND THIRD PARTIES. (ALL) A

a) Every client is assessed a fee.

b) The Board adopts a fee schedule that is approved by the Department of Institutions.

c) Adjustments to the collected portion of fees are made according to a client's ability to pay.

d) The Board has procedures for recording all accounts receivable in the general ledger, and a formal procedure for write off of uncollectable accounts.

e) Procedures for billing and fee collection are specified and carried out.

f) Fees are charged to third parties whenever possible.

g) Fees charged and collected by contract agencies are systematically reported to the Board.

PERSONNEL MANAGEMENT

To a very large extent, the overall effectiveness of the Board to provide comprehensive mental health services will be contingent on the quality of its personnel management system. Commensurate with the program size, such a system should be based on comprehensive, written personnel policies and procedures which govern salaries, fringe benefits, hiring and promotional criteria, termination of employment, and define staff responsibilities and limitations. Formal policies should also be established that specify channels of communication between staff and management for mutually satisfactory resolution of employer/employee conflicts. Such policies and procedures should include procedures relating to responsibilities, privileges, and limitations on volunteers, students and interns.

The Board may elect to develop its own personnel management system or it may adopt the State Merit System. Regardless of the method chosen, it should have on file and readily accessible to all employees a complete set of policies and procedures that are consistent with the Community Mental Health Center Standards.

5.1 THE BOARD HAS A COMPREHENSIVE SET OF WRITTEN PERSONNEL POLICIES AND PROCEDURES. A

These include: (Required)

a) A salary schedule covering all positions.

b) Hiring and promotional procedures which are non-discriminating by reason of sex, age, race, irrelevant disability, creed, or marital status.

c) A procedure for suspension and/or dismissal of an employee which includes opportunities for appeal, and requires clear and orderly progress toward such actions with prior warning to the employee.

d) A grievance procedure which allows employees to adequately express their dissatisfaction over employment conditions and assures a fair resolution of expressed problems.

e) Provision for making authorized exceptions to the rules as needed for individual employees.

f) A description of the extent and nature of probation periods for newly hired or promoted staff.

g) Provision to ensure that employees are regularly evaluated by their supervisor as to the degree to which the Center is satisfied with their job performance.

h) Provision for the ongoing review of personal procedures, which include provision for Center staff input.

i) Policies governing an employee's access to his personnel files.

j) Provision for any fringe benefits the Board may provide, such as health insurance, retirement programs, professional liability, insurance, etc.

k) Provision for holiday leave, sick leave, vacation leave, compensatory leave, and other types of absences including specific procedures for written requests and written approval of such leaves.

l) A description of activities such as outside employment which may cause a conflict of interest, and a description of limitation on employee participation in such activities.

m) Reimbursement procedures for expenses incurred by employees in the line of duty including overtime pay for clerical employees.

(Recommended if Necessary)

a) Definition of the responsibilities, privileges, and limitations on students, interns, volunteers, and trainees employed at the Center.

b) Definition of the responsibilities and limitations of part-time employees, and employees hired on a contracted basis.

c) A description of Center expectation regarding the ethical behavior of its employees.

5.2 THE BOARD HAS WRITTEN JOB DESCRIPTION AND QUALIFICATIONS FOR EACH STAFF POSITION (3 of 4) B

a) Job descriptions are derived from program goals.

b) Job descriptions are written in terms of specific tasks and responsibilities of the position.

c) Job qualifications are written in terms of training and experience, and reflect the skills, attitudes and knowledge needed by staff to adequately perform job functions.

d) Job descriptions and qualifications for each position are available to all staff.

5.3 THE BOARD HAS PROVISION FOR ENSURING THAT STAFF POSSESSES THE SKILLS, ATTITUDES AND KNOWLEDGE NEEDED TO PERFORM JOB FUNCTION AT THE TIME THEY ARE HIRED, PROMOTED, OR TRANSFERRED TO A POSITION. B

These include: (ALL)

a) Written procedures for hiring, promoting or transferring staff, including mechanisms for screening and evaluating candidates.

b) A provision to have on file documents which support employee qualifications for their positions, including educational transcripts, licenses, certificates, etc.

5.4 THE BOARD PROVIDES FOR REGULAR EVALUATION OF THE JOB PERFORMANCE OF EACH STAFF PERSON. (3 of 4) B

a) This evaluation is performed at least twice during an employee's first year, and at least once a year thereafter.

b) Evaluations assess the degree to which each staff person is performing the tasks described in his job description and the degree to which he possesses the skills, knowledge, and attitudes defined by the job qualifications of his position.

c) The factors upon which these evaluations are based are communicated to staff (in writing) at least ninety days before they are evaluated.

c) The results of evaluations are communicated in writing to the evaluated staff person and to supervisors who are involved in staff placement.

PROGRAM ADMINISTRATION

Program administration is divided into four sub-sections: Personnel, Management, staff development, interagency coordination, and program evaluation. In general, each subsection addresses the policies and procedures that should be implemented at the individual program level.

Personnel Management

Although section five was also entitled Personnel Management and dealt with the administration function of the Board; this present section deals with the actual implementation of a personnel management system at the program level. Management of the system should be assigned to one or more staff at the center. Job descriptions and qualifications should be maintained for all staff when employed by the Center. There should be a policy to ensure that staff members possess the skills, attitudes and knowledge needed to perform job functions, and provisions for performing regular staff evaluations. Written definitions and procedures for use of all volunteers should be maintained.

Staff Development

The Center should have a written plan for orientation of new staff, continuing education activities and staff development. These activities should be related to specific program goals and may include support of staff attendance at conferences, visits to other agencies, use of consultants, joint interagency conferences, or educational presentations within the Agency.

Interagency Coordination

Provision of comprehensive mental health services necessitates a close working relationship be established with other State and community human service

agencies. The effectiveness of such interagency coordination greatly influences the degree to which continuity of care becomes a functional reality. As a basis for interagency coordination, the Center must be aware of the specific program goals of other human service agencies, and be provided with current information regarding the types of services offered and any limitation on these services. Similarly, the Center should ensure that other human service agencies receive accurate, up-to-date information regarding the Center's programs.

Program Evaluation

The Center should have the capability to assess the degree to which each of its programs is meeting their established goals and objectives. The Center's evaluation system should provide Center management with such information as necessary to formulate long range planning and budgeting including such quantitative aspects as the Center's caseload, staff utilization and, when feasible, qualitative aspects such as client satisfaction. Although the Center may certainly use information provided through the State, the evaluation program should be designed and implemented to meet the specific informational needs of the Center's management.

Volunteers and Staff Development

6.1 WHEN VOLUNTEERS ARE USED, THE PROGRAM HAS CLEAR WRITTEN DEFINITIONS AND PROCEDURES FOR VOLUNTEERS.

These definitions and procedures include: (5 of 8)

a) Procedures and criteria for selecting volunteers.

b) Procedures and criteria for training volunteers.

c) Procedures and criteria for supervising volunteers.

d) A provision for making agreements with volunteers regarding responsibilities (job descriptions) and time commitments.

e) A provision describing the limitations on and privileges of volunteers, including access to files, meetings, etc.

f) A description of the extent to which volunteers may be held liable for their actions at the Center.

g) A description of any reimbursements to be made by the Center.

h) Provisions for malpractice insurance and personal injury or Worker's Compensation insurance.

6.2 THE CENTER PLANS AND IMPLEMENTS A COMPREHENSIVE STAFF DEVELOPMENT PROGRAM (4 of 6)

a) The staff development plan is written on an annual basis, and describes the type and frequency of activities.

b) Staff input concerning topic areas is solicited during the initial planning and implementation of the program.

c) Topic areas selected for presentation are related to program goals. When the relationship between the topic area and program goals is not obvious, written justification for those activities should be entered in the plan.

d) Staff development activities occur according to the plan.

e) There are policies and procedures regarding staff attendance at staff development activities.

f) There are procedures for reimbursement of expenses when appropriate.

Interagency Coordination

6.3 THERE ARE ADEQUATE PROVISIONS WHEREBY THE CENTER COORDINATES WITH OTHER HUMAN SERVICE PROGRAMS AND AGENCIES IN THE COMMUNITY TO ENSURE CONTINUITY OF CARE. (3 of 4) B

a) Staff participate in interagency case conferences.

b) There are written continuity of care agreements between agencies that provide services to the population served.

c) The program has provisions for surveying other community agencies regarding these agencies' degree of satisfaction with its service and interagency coordination. This survey is performed at least annually, and the results are documented.

d) The Center makes efforts to invite pertinent community agencies to appropriate staff development activities.

6.4 THE CENTER HAS PROVISIONS FOR EXPLAINING ITS SERVICES AND PROGRAM GOALS TO ALL PERTINENT AGENCIES AND PROGRAMS IN THE COMMUNITY. (ALL) B

a) The Center distributes current written information on its services to appropriate agencies.

b) The Center meets with (appropriate) agencies at least annually for the purpose of promoting coordination of services.

6.5 THE CENTER MAINTAINS CURRENT WRITTEN INFORMATION ON EVERY COMMUNITY AGENCY TO WHICH IT MAY REFER CLIENTS. B

This information includes: (ALL)

a) Address and phone number

b) Specific services offered

c) Admission criteria

d) Referral procedure

e) Waiting list

f) Cost of service

Program Evaluation

6.6 THE CENTER HAS PLANNED AND IMPLEMENTED AN EVALUATION SYSTEM WHICH IS ADEQUATE TO DETERMINE THE DEGREE TO WHICH SERVICE ACTIVITIES MEET CURRENT PROGRAM GOALS AND OBJECTIVES. (REQUIRED) B

a) Quantitative characteristics (e.g, caseload information, referral source, staff activities) are systematically monitored.

b) Qualitative characteristics (e.g. measure of client progress, client/family satisfaction) are systematically monitored.

(RECOMMENDED)

c) Data collection procedures used by the program are minimally disruptive to the operations of the program.

d) The users of the program monitoring system have opportunities to make input into the planning and ongoing refinement of the system.

6.7 EVALUATION REPORTS ARE PRODUCED BY THE PROGRAM AT A FREQUENCY APPROPRIATE TO THE ACTIVITIES BEING MONITORED AND CLEARLY DESCRIBE THE OUTCOME OF THE EVALUATION. (ALL)

a) Reports are based on data which are current, accurate, and relevant to the goals and objectives being monitored.

b) Data are interpreted and summarized into useful information.

c) Reports include recommendations for remediative action where necessary.

SERVICE DELIVERY:
Policies and Procedures

Service Delivery: The Policies and Procedures of the Service Delivery section is divided into four subsections: Confidentiality, Service Planning and Documentation, Prevention Services and Emergency Services.

Confidentiality

By the very nature of comprehensive mental health and the necessary interagency planning for client service, the Center will frequently be asked to release client information to another human service agency or to the client himself, or may request such information from another agency. Explicit guidelines must be established and adhered to that will provide maximum protection to the clients' right of privacy, while allowing an exchange of essential information between appropriate agency's or personnel. The Center should make it a practice to inform clients of their policies regarding release of client information, indicating the types of information it must share and the conditions under which it must be shared. A sample of each type of release of information form the Center uses (including forms used to release, and to acquire information) should be available and explained to each client for whom a transfer of information is anticipated.

The protection of priviliged information within the Center itself is also important. The Center should have written policies and procedures regarding the security of client records. Also policies should protect client information from indiscrete or indiscriminate discussion among program staff, volunteers, etc.

Service Planning and Documentation

This section addresses those policies and procedures that the Center should implement with respect to case records, including 1) The Center's intake procedure, 2) the procedure used when planning and documenting services, 3) the role and function of the case coordinator, and, 4) case record review.

Policies for intake should include a description of each step of the procedure from the initial contact to the actual implementation of services. Where feasible, time frames for completion of major steps should be defined and persons responsible for ensuring that each step is completed should be identified.

Inasmuch as review of case records is one means of assessing a clinical program adequate policies and procedures for case documentation are especially important. Such policies and procedures should describe a systematic process of service planning, intervention and record maintenance, and should include a description of when and how cases are to be opened and closed. The policies should also describe the duties of case coordinators and how they will be assigned to clients. The basic responsibility of the case coordinator is to ensure that his assigned clients receive all needed human services. The case coordinator may be the client's primary therapist or worker, work supervisor or an individual who is assigned the case coordinator function for the entire Center.

The Center should have policies and procedures which govern three types of record reviews: 1) a review of client's Individual Service Plans performed by the client's therapist or primary worker (see Status Report in Section 9), 2) a qualitative review of the service plan by a committee of peers (Utilization Review), and 3) a review of case records to ensure that they contain all documentation required by agency procedures and the STANDARDS. The latter review may, in fact, be part of the individual or peer review procedures.

The peer review should be performed on an ongoing basis (at least monthly) of a representative sample of Center files. This process should monitor the quality of care being provided to clients, the length of treatment, and the quality of case record maintenance. A report describing the committee's findings, recommendations, any action to be taken, and data for follow-up should be prepared for each record review. Written procedures should describe the methods for selecting committee members, selecting records for review, preparation of committee reports, and the frequency with which the committee will meet. The record sampling pro-

cedures used will dictate how many records are ultimately reviewed, although ideally, every active record of ongoing treatment should be reviewed at least once during the course of service.

Prevention Services

The Center should address the issue of prevention. Inpatient and Outpatient Services, in particular, should have written procedures to assess the needs of family members of clients. These procedures should include a description of the conditions under which family members will be approached (including client consent), the types of assessments that will be used for child and adult family members, and the steps to be followed when a need is identified.

Emergency Services

Whether it operates or contracts for its Emergency Services program, the Center should ensure that it has a complete set of policies and procedures to govern its operation. These policies and procedures should include a description of staff duties and responsibilities, personnel qualification, how services should be documented, Center limitation and responsibilities, how the system will be tested, and a description of the training program to be used.

Confidentiality

7.1 THE PROGRAM MAINTAINS A COMPLETE SET OF WRITTEN POLICIES AND PROCEDURES WITH RESPECT TO PROTECTING, COMMUNICATING AND ACQUIRING CLIENT INFORMATION.

These include: (ALL)

a) A description of the conditions under which client information may and may not be released, including a description of the conditions under which written permission for release of information is and is not required from the client.

b) Procedures for securing information about clients from other agencies, and for the subsequent confidentiality of that information.

c) A sample of each type of release of information form used by the program. These forms should specify to whom the information will be released and the conditions or time at which the release form will be effective.

d) A provision that all approved release of information forms will be stored in individual case folders.

e) A provision governing the protection of client information, which ensures the security of records and client information at all times.

f) A provision regarding the length of time that records of terminated clients will be retained and how these records will be destroyed.

g) A provision describing the conditions under which a client may have access to information contained in his case record.

h) A provision that during the intake interview clients will be informed about priviledged communication, including the types of information and the condition under which that information must be released, and to whom it will be released.

Service Planning and Documentation

7.2 THE PROGRAM HAS A COMPLETE, WRITTEN DESCRIPTION OF ITS INTAKE PROCEDURE. (3 of 5)

a) Each step of the procedure is defined.

b) Time lines are given for completion of major steps.

c) Staff responsibilities regarding completion of major steps are defined.

d) The intake procedure includes provisions for clients who are experiencing emergencies.

e) There is evidence that the intake procedure has been implemented.

7.3 THE CENTER MAINTAINS A COMPLETE WRITTEN DESCRIPTION OF THE POLICIES AND PROCEDURES ITS STAFF USED IN SERVICE PLANNING, DELIVERY AND DOCUMENTATION. B

These policies at a minimum include: (ALL)

a) A description of the procedures staff will use in service planning which includes provisions for written client assessments, identification of service goals and development of treatment plans.

b) A provision whereby the agency places emphasis on the involvement of the client and on significant others in developing and carrying out treatment plans.

c) A description of the procedures and time frames for preparing intake interviews, treatment plans, progress notes and termination reports.

d) A provision which describes when and how cases will be closed.

e) A description of how the contents of the case record should be organized.

7.4 THE CENTER MAINTAINS POLICIES AND PROCEDURES TO ENSURE EACH CASE IS COORDINATED THROUGH A DESIGNATED INDIVIDUAL. A

These include: (ALL)

a) A provision that a case coordinator shall be assigned to each client, and that the duties of each case coordinator will be described to each client (or responsible adult) by the second service contact.

b) Duties and responsibilities of the case coordinator are specified in writing and include:

1) Coordinating the implementation of the Individual Treatment Plan (ITP).

2) Monitoring the service provided for his clients to ensure that the ITP is followed, reassessed and modified as necessary.

3) Scheduling intra- and interagency conferences on clients as they are needed to coordinate services and to evaluate client progress.

4) Maintaining a current, written record of all mental health and other human services the client is receiving, as well as records of the results of intra- and interagency communication regarding the client.

7.5 THE CENTER MAINTAINS A COMPLETE WRITTEN DESCRIPTION OF THE POLICIES AND PROCEDURES USED TO REVIEW CLIENT CASE RECORDS. (ALL) B

a) Ongoing review to determine whether records contain all the service documentation and release of information documents required by the Center and the CMHC Standards.

b) Periodic review and updating by individual therapists of their client's ITP at a frequency appropriate to the rate and intensity of service (at least quarterly).

c) Periodic review of a reasonable percentage of randomly selected records by a committee of peers (Utilization Review)

Prevention Services

7.6 THE CENTER HAS A WRITTEN PLAN COVERING THE STEPS TO BE TAKEN TO ASSESS THE NEEDS OF FAMILY MEMBERS OF CLIENTS WITH DUE REGARD FOR CLINICAL APPROPRIATENESS AND THE CONSENT OF THE CLIENT. (ALL)

a) Children of adult clients: The Center has procedures for routine assessment of the child's risk status, and the family's needs and the child care capabilities: 1) When a severely disturbed patient or a mentally retarded parent is admitted to services; 2) When inpatient discharge planning is undertaken.

b) Children of adult clients: The Center has procedures to assure that attempts are made to provide stable care arrangements when a primary caregiver is admitted to inpatient or residential care, or is otherwise unable to meet and fulfill child care needs.

c) Adult family members of adult or child clients: The Center has procedures for meeting the mental health needs of family members.

Emergency Services

7.7 THE EMERGENCY SERVICE SYSTEM OPERATES WITHIN CLEARLY DEFINED GUIDELINES AND PROCEDURES.

These include: (Required)

a) A clear description of the duties and responsibilities of the individuals who provide the service (including the steps to be followed in handling emergencies).

b) A description of the qualifications required of the persons who provide the service.

c) A provision to ensure 24-hour telephone service.

d) A description of the procedures to be followed in documenting the delivery of emergency services. These should, at minimum, address identifying information, description of the problem, and action taken.

(Recommended)

a) A provision for regular testing and updating on the responsiveness and adequacy of the system such as periodic follow-ups of emergency cases.

b) A provision to ensure that adequate training is provided for all persons providing emergency service.

SERVICE DELIVERY:
Accessibility

The Center's program, including its satellite offices should ensure that their services are readily accessible to actual and potential clients. Such accessibility not only includes how easily a client may acquire services, but also whether he will want to continue to receive services until he no longer needs them. Thus, accessibility is influenced by both physical and social factors.

To the extent possible, the Center and satellite offices should be located near the majority of people in its client population, and should be within walking distance of public transportation routes. Any fees charged should be individualized and commensurate with each client's ability to pay. The program should be able to initiate services immediately in the case of emergencies, and within one week of request in the case of non-emergencies.

As much as possible, the Center should offer services that are tailored to their lifestyle, needs, and characteristics of its clients. Services should be offered at times which are compatible with client's schedules, that is, at times other than regular work or school hours.

SERVICE DELIVERY:
Accessibility

8.1 THE PROGRAM IS LOCATED WITHIN A CONVENIENT DISTANCE FROM POTENTIAL OR ACTUAL CLIENTS. (ALL) B

a) Programs in urban areas are located within thirty minutes driving time of potential and actual client's homes.

b) Programs in rural areas are located within sixty minutes driving time of potential and actual clients' homes.

c) In areas where public transportation is available, the program is within walking distance from public transportation routes.

8.2 SERVICE FEES SET TO BE COLLECTED FROM CLIENTS CORRESPOND TO THE CLIENTS' ABILITY TO PAY. (ALL) A

a) The Center has a written fee collection schedule that is approved by its governing board and Department of Institutions.

b) The Center has provision for involving clients in the determination of fees.

c) Fees should be equitable throughout catchment area.

8.3 SERVICES TO CLIENTS ARE INITIATED SOON ENOUGH AFTER THEY ARE REQUESTED TO BE MAXIMALLY CURRENT AND USEFUL TO CLIENTS. (ALL) A

a) For clients who are experiencing emergencies, services are initiated with sufficient immediacy to match the urgency of the service request.

b) For clients who are not experiencing emergencies, services are initiated within one week of request. (Initiation of services may be an assessment interview or an intake interview at the beginning of an ongoing service program, and/or a scheduling of a subsequent contact date).

c) There is no evidence of significant service overloads, such as excessive waiting lists.

8.4 THE CENTER OFFERS SERVICES THAT ARE TAILORED TO THE LIFESTYLE, NEEDS, AND CHARACTERISTICS OF THE CLIENTS IT SERVES. (2 of 3) B

a) The Center offers a range of intervention modalities appropriate to the needs of its service population.

b) The Center offers outreach services.

c) Services are offered to clients at times that are compatible with their schedules so as to be minimally disruptive to other essential functions in their lives (e.g. work, school, child care, public transportation schedules, etc.). When participation by significant others (family,

friends, etc.) is appropriate, allowances should be made for their schedule.

8.5 THE PHYSICAL AND SOCIAL ENVIRONMENTS OF THE CENTER ARE FREE OF ANY FEATURES THAT MAY BE POTENTIALLY OFFENSIVE TO CLIENTS. B

a) The Center has developed a plan for delivery of services to handicapped clients affected by physical barriers such as home visits or temporary use of other, barrier-free offices.

b) The Center is free of social barriers to clients. This means the Center's decor and the manner in which its staff interact with clients is both age and/or culturally appropriate to its client population.

c) The physical plant ensures privacy for clients when appropriate. This may include measures for sound-proofing therapy and counseling rooms.

APPENDIX D

PERCENT OF POPULATION BELOW POVERTY LEVEL

REGION I

Carter	17.5	Prairie	19.1
Custer	11.6	Richland	13.8
Daniels	10.1	Roosevelt	23.3
Dawson	8.4	Rosebud	25.8
Fallon	12.6	Sheridan	11.4
Garfield	17.3	Treasure	22.8
McCone	13.8	Valley	16.8
Phillips	16.6	Wibaux	15.2
Powder River	13.0		
		Regional	15.1

REGION II

Blaine	31.4	Liberty	8.4
Cascade	10.9	Pondera	18.2
Chouteau	11.6	Teton	12.0
Glacier	29.5	Toole	11.6
Hill	14.8		
		Regional	14.1

REGION III

Big Horn	25.3	Petroleum	17.8
Carbon	19.2	Stillwater	13.7
Fergus	14.9	Sweetgrass	23.6
Golden Valley	11.7	Wheatland	16.3
Judith Basin	15.2	Yellowstone	12.1
Musselshell	19.2		
		Regional	14.3

REGION IV

Beaverhead	17.4	Lewis & Clark	8.8
Broadwater	23.1	Madison	18.1
Deer Lodge	10.8	Meagher	24.9
Gallatin	11.1	Park	14.3
Granite	15.8	Powell	9.5
Jefferson	13.4	Silver Bow	11.4
		Regional	11.8

REGION V

Flathead	12.9	Missoula	11.2
Lake	22.3	Ravalli	18.6
Lincoln	7.1	Sanders	14.0
Mineral	8.4		
		Regional	13.0

Region I has been designated by National Institute of Mental Health as meeting poverty classification status in Montana. Additionally, Region III has been found to meet the statistical requirements for designation as a poverty area.

APPENDIX E

Progress Report on 1979 Goals and Objectives

GOAL #1:

Objective 1 (a) Partially accomplished. Progress during the 1979 year included further development of a single state plan, with several discussions being conducted with the Alcohol and Drug Abuse Division, Health Systems Agency and The Department of Health. To date the Alcohol and Drug Abuse Division may join the Mental Health & Residential Services Division in the development of a single plan. The other agencies intend to further instigate specific aspects of coordination before fruition.

1 (b) The Mental Health & Residential Services Divison did assume budget reductions during the 1979 General Legislature; however, contingency funding from private fees, county mill levees and other revenue areas has yielded as stable base as possible for program maintenance without new service expansion.

1 (c) Legislation for the accomplishment of (a) & (b) was unsuccessful.

Objective 2: Partially accomplished. Formal role delineation and specific responsibilities for CMHCs has been

accomplished. However, these processes remain for WSSH, the State Council and the private sector.

Objective 3: Accomplished. In June of 1978 the Departments of Psychology, Sociology, Social Work and Education at the University of Montana completed their final report "Mental Health Needs Assessment: Warm Springs Related Population". This document provided an objective, cross disciplinary, multi-departmental guide of patient needs and community resources for the WSSH patient, as well as of the patients' needs previously discharged.

Objective 4: Accomplished. The CMHCs report quarterly to the Mental Health & Residential Services Division in regard to patient movement.

Objective 5: Accomplished. The CSP has established a replicable model for the deinstitutionalized severely mentally disabled adult in Region III and will duplicate this model in Region I during 1979-80.

Objective 6: Not Accomplished. Although this objective has been discussed among the agencies. A formal meeting has not been conducted. This objective is ongoing for the 1980 plan.

GOAL #2;

Objective 1: Accomplished. All patients for WSSH, Galen and Center for the Aged have been reviewed for appropriate placement. Specific plans including time tables for most of the population who are inappropriately placed have been established.

Objective 2: Accomplished. See organizational chart in Public Mental Hospital section.

Objective 3: Accomplished. This objective is ongoing.

Objective 4: Partially accomplished. Three of the five CMHCs have had site evaluations. This will be completed by August 1979.

a) Accomplished. Community living arrangements in each region have been established. They are Region I - 1, II - 4, III - 6, IV - 1 and V - 2.

b) Partially accomplished. With the assistance of manpower and CSP the CMHCs have developed plans for specialized services for Indians, Child and Elderly excluding Region I's plan for Native Americans. Reports on the results of these plans will be an objective for 1980.

c) Accomplished. Each CMHC has developed day treatment/day care programs. Region I - 3, II - 4, III - 2, IV - 2, V - 2.

d) Partially accomplished. Some CMHCs have developed on-job training, workshop, traineeships and competitive employment programs for deinstitutionalized clients. This objective is ongoing and more empirical data will be presented in the 1980 plan.

e) Partially accomplished. All CMHCs have established a system of services to serve their respective populations as close to home as possible with the exceptions noted in 4-b.

f) Accomplished. Each CMHC has identified the chronic psychiatrically disabled client in nursing and boarding homes in its catchment area.

g) Accomplished. Each CMHC is providing services to chronic psychiatrically disabled clients in nursing and boarding homes as related to their needs.

Objective 5: Accomplished. A plan, budget and site availability was developed for an intermediate care facility for emotionally disturbed children.

Objective 6: Accomplished. An action plan was developed and presented to the legislature. This goal is ongoing.

GOAL #3:

Objective 1: Partially accomplished. All CMHCs have developed consultation and education programs with existing staff, however more aggressive development in this area is being requested by the Mental Health & Residential Services Division.

Objective 2: Accomplished. All CMHCs have developed role responsibilities in regard to coordination of mental health services in their respective judicial districts.

Objective 3: Accomplished. During May 1979, the Mental Health & Residential Services Division with the assistance of Manpower presented a conference with the Mental Health Association of Montana. In addition, Manpower is planning other joint public information activities.

Objective 4: Accomplished. The Mental Health & Residential Services Division has a weekly column which presently appears in 9 state newspapers. This

column written by Bailey Molineux, Ph.D., deals with many aspects of mental health.

Objective 5: Accomplished. Each CMHC has identified at least one population at risk and has developed a primary prevention program to deal with members of those populations.

Region I - Abused wives & parents
Region II - Teenage mother & Native Americans
Region III - Single parents & families with one member involved in substance abuse
Region IV - Abused children
Region V - Children

Objective 6: Accomplished. A five year Manpower Development Program in cooperation with the National Institute of Mental Health has been established within the Department of Institutions, Mental Health and Residential Services Division. All staff for this program have been recruited and hired.

a) Accomplished - See Manpower section.

b) Partially accomplished - See Manpower section.

c) Accomplished - See Manpower section.

d) Accomplished - See Manpower section.

Progress and Plans

Goal 1: Coordination/Policy

Objective 1. Leadership Development

Assessments of needs for leadership and management development have been accomplished for (1) Mental Health Division staff and (2) mental health center administrative staff. A training workshop for the Mental Health Division staff was conducted to re-examine and redefine the Division's mission and their goals and to relate these to problem solving methods within the Division's organizational structure.

Objective 2. System Cooperation

A number of pilot contacts have been made to plan for a personnel exchange program between the CMHCs and the Warm Springs State Hospital. Other exchange possibilities, such as university faculty and direct service providers, may also be considered. The exchange program will promote intimate involvement of both clinical and administrative staffs. This should contribute to greater role empathy and cooperation.

Objective 3. Governing/Advisory Board Development

Meetings have been held with a number of governing board members throughout the state, as well as with CMHC professional personnel, concerning training needs of governing and advisory boards. Manpower staff

members have attended governing and advisory board meetings and informally assessed their needs. A formal needs assessment survey is now being developed for statewide mailing.

Objective 4. Prevention Through Education

A joint meeting with the Montana Mental Health Association promulgated the film purchase "Learning to Cope," which was produced by the National Mental Health Association, and to train MMHA members in its use with other audiences in the state.

Several mental health video tapes for use on the MTN television network have been completed. Four "Tel Med" tapes for professional development of primary care physicians have been developed on mental health topics. Initial contact and development of the mental health portion of a program for primary prevention through health education has been initiated in cooperation with the State Department of Health, Division of Preventive Services. Funding for a weekly MTN radio broadcast, "Vital Signs", has been obtained through cooperation with MTN and Blue Cross. The program will deal with prevention concerns in both physical and mental health.

Objective 5. To Develop Standardized Criteria for Program Licensure.

Although this objective has not received as much attention as have the other state manpower objectives, there has been initiated an exploration with the Montana Board

of Psychologists of the pros and cons of licensing mental health paraprofessionals and clergy involved in pastoral counseling. In addition contacts have been made with the Department of Health and Environmental Sciences for review of the laws applicable to mental health centers and half-way houses. A licensure bill was presented to the Legislature but subsequently failed, however, cooperative planning for updating the law continues.

GOAL 2.

Objective 1. Pre-Service Education

Approval has been received from NIMH for a proposal to develop a pre-service program for Clinical Associates to the Manpower Development Project. The program will involve training of both all but dissertation finished and post-doctural associates. The program will have a strongly rural orientation and will emphasize service to children, elderly, minorities, and underserved groups.

Objective 2. Continuing Education/Staff Development

Contacts have been made with each of the CMHCs and with several of the institutions to informally assess continuing education and staff development needs. Discussion has been held with the School Counseling Consultant of the Office of Public Instruction and with representatives of the Montana clergy to begin to determine staff develop-

ment needs of these groups as pertains to mental health. Numerous resources for staff development and continuing education both in-state and out-of-state have been identified.

Objective 3. Paraprofessional Utilization

A literature review of more than eighty relevant documents on training and utilization of paraprofessionals in mental health is now in progress. Plans for an off reservation Indian Research Project were introduced to the Montana United Indian Alliance (MUIA) and as a result 700 questionnaires have been distributed in a survey of the needs of off-reservation Indians. The goal of the project is to better prepare Indians who plan to leave reservations for the stresses of off-reservation life.

A paraprofessional project to serve off-reservation Indians through MUIA offices has been approved and awaits NIMH funding.

Objective 4. Volunteer Integration

Meetings have been held with several agencies which operate successful volunteer programs in an effort to identify the elements of such a program. A literature review is being conducted in order to study successful volunteer efforts in other states. In cooperation with the Region III Mental Health Center, a proposal has been written and submitted to ACTION for the implementation

of a volunteer case management system in that region.

Objective 5. Natural Provider Development

While this objective has not yet received the attention it deserves we have, during the past six months:

a) conducted a training event for beauticians on identifying and referring clients with mental health problems and,

b) Made contact with 2 natural provider programs and initiated plans to study those programs.

COORDINATION OF PLANNING

Many public and private agencies throughout the State of Montana are involved in the provision of human services. These human service agencies often have functions and responsibilities which overlap or duplicate other human service agency efforts. Because these agencies have separate organization structures the potential for duplicated services, unmet service needs, and inefficient delivery of multiple services to individuals is significant. The Department of Institutions recognizes the need for a coordinated approach to services planning and delivery, and is committed to this coordination in the provision of mental health services.

Health Planning

It is anticipated that the State Plan for Mental Health will stand as a companion document to the State Plan for Health for a total view of what should be done in Montana in regard to total health services. The present health planning organization within Montana changed October 1, 1976 as per Public Law 93-641. The Montana Health Systems Agency has been established

to develop health plans for the sub-area planning districts of Montana. To coordinate planning efforts, the Mental Health Advisory Committee and the Mental Health and Residential Services Division will be participating with the Health Systems Agency and the State Planning and Health Development Agency in evaluation of planning for health in mental health programs throughout the state.

- Licensing requirements for community based group homes or alternate living facilities.
- Approval of applications for construction of mental health facilities.
- Coordination of community-based health and mental health programs and personnel.

Further, coordination between State Health and Mental Health agencies and Regional Mental Health programs is enhanced by representation on the Statewide Health Coordinating Council. Coordination is also facilitated on an areawide basis by representation of the Council of Regional Mental Health Boards on the executive division of the Montana Health Systems Agency Governing Board. The Regional Director of the South Central Mental Health Center serves as Chairman of the Statewide Coordinating Council as well as the Governing Board of the Health Systems Agency.

At present, this Plan is consistent with the State Health Plan published in August 1974 under Section 1524(c) (2) of the Public Health Services Act. The State Mental Health Plan will be given to the Statewide Health Coordinating Council and the Health Systems Agency Governing Board for review and approval.

Other Human Services

State agencies responsible for human services meet at least twice a month. The purpose of the meetings are to coordinate planning among

agencies for service delivery. Representatives include the Governor's Office, Department of Institutions, Social and Rehabilitation Services (State Title XX Agency), Community Affiars, and Health.

Alcohol and Drugs

The role of division administrators of the Alcohol and Drug Abuse Division and the Mental Health and Residential Services Division to insure that a coordinated effort in planning for community based service delivery is an on-going process between the divisions' staff. An example of this coordinated effort is in the planning and conducting of site evaluations. Evaluation sections of both divisions have worked out a coordinated site evaluation schedule so they can evalute community agencies providing both mental health and alcohol services during one site visit.

Community Planning

As stated in the purpose of the Plan, the Department of Institutions aims to provide a mechanism for communication between the Department and other local organizations involved in the delivery of mental health services. Communication is seen as a necessity for responsive and efficient services. No one center, agency or facility can alone provide adequate services to meet the myriad needs of the citizenry. It is necessary to establish a climate of mutual cooperation and understanding in order to obtain comprehensive care.

As previously discussed, the Community Support Project within the Mental Health and Residential Services Division is taking the lead role in developing a support system which will rely on the close interaction between mental health service agencies and mainline agencies to improve community care for the mentally ill.

Appendix F

Report on State Advisory Council Meetings

During the 1979 year the State Mental Health Advisory Council met two days every other month. In addition to the council members a division staff member attended each meeting. The Council had a plethora of issues to be dealt with however major Council activities during the last year included:

a. Consultation in development of the 1980 State Mental Health Plan.

b. Four reviews of the goals and objectives of the 1979 State Plan.

c. The compilation of sixty-four recommendations to improve mental health services in Montana and their presentation to the Governor, Legislature and Department of Institutions.

d. Coordination of the executive departments of government to:

   1. improve services at the children's unit in WSSH.
   2. to develop a community intensive care unit for emotionally disturbed children.

e. Consultation in the "deinstitutionalization" procedure of WSSH.

f. Consultation in the development of the HSA State Plan.

g. Presentations at the State Mental Health Association Convention and,

h. development and presentation of information to legislators related to improved mental health services.

Additional information may be obtained from the Chairman, Mental Health Advisory Council, Capitol Station, Helena, Montana 59601.

V

ATTACHMENTS

APR 1 5 1976

State of Montana
Office of The Governor
Helena 59601

Attachment 1

THOMAS L. JUDGE
GOVERNOR

April 13, 1976

Dr. Robert Mattson, Director
Department of Institutions
1539 11th Avenue
Helena, Montana 59601

Dear Bob:

In accordance with P.L. 94-63, the new Comprehensive Mental Health Act, I am designating your department as the single state agency for preparation of both the Mental Health Construction Plan and the Comprehensive Mental Health Plan for the State of Montana.

I look forward to receiving your recommendations for persons to serve on the Mental Health Advisory Council which will be reviewing the Mental Health Plan this spring.

Since the Department of Health and Environmental Sciences is designated as the department to prepare the State Health Plan and to do specific plan reviews and approvals, I expect that you will need to coordinate closely your work with theirs. If there is any way in which my office can be of assistance, please let me know.

Best regards.

Sincerely,

Tom

THOMAS L. JUDGE
Governor

cc: Dr. A. C. Knight
Dr. Stanley Mahoney

RECEIVED
APR 15 19..
DEPARTMENT OF
INSTITUTIONS

STATE OF MONTANA
DEPARTMENT OF ADMINISTRATION
MERIT SYSTEM COUNCIL
MITCHELL BUILDING
HELENA 59601

April 20, 1979

Mr. Peter Blouke, Administrator
Mental Health and
Residential Service Division
1539 Eleventh Avenue
Helena, Montana 59601

Dear Mr. Blouke:

The Montana State Merit System Council Rules have been developed in accordance with the Federal Standards for a Merit System of Personnel Administration. The Federal Standards are listed as Code of Federal Regulations 5, Part 900, Subpart F. Our rules and regulations, in addition to being approved by Merit System agencies and the Merit System Council, must be approved by the U.S. Office of Personnel Management.

I can assure you our rules and regulations are in compliance with the Code of Federal Regulations regarding the standards for a Merit System of personnel administration.

Sincerely yours,

James A. Silberberger, Chief
Merit System Bureau

JAS:bj

AN EQUAL OPPORTUNITY EMPLOYER

Attachment 3

State of Montana

Department of Institutions

Mental Health and Residential Services Divisions

GOVERNOR
THOMAS L. JUDGE

DIRECTOR
LAWRENCE M. ZANTO

DIVISION ADMINISTRATOR
LAURANCE B. CARLSON

1539 Eleventh Avenue
Helena, Montana 59601
Telephone (406) 449-3964

May 14, 1979

Peter S. Blouke, Ph.D., Administrator
Mental Health and Residential Services Division
Department of Institutions
Helena, Montana 59601

Re: Mental Health Compliance with Non-Discrimination

Dear Dr. Blouke:

After examining the current law in Montana, it is my opinion that the several mental health corporations which we contract with to provide mental health services must comply with both federal and state law concerning non-discrimination as far as services and employment.

Under federal law, Title 6 of the 1964 Civil Rights Act and 42 USE, Section 2000D, agencies receiving federal funds must be in complete compliance with non-discrimination policies. Further, the 1972 Montana constitution and Title 49 of the Montana Codes Annotated, insures that there is no discrimination in Montana. To do so, would be a clear violation of both federal and state law. I feel that our contracts with the mental health centers guarantee that there is compliance to both federal and state law as to non-discrimination.

I view this as compliance with accepted standards.

Very truly yours,

Nick A. Rotering

Nick A. Rotering
Special Assistant Attorney General
for the Department of Institutions

NAR/clk

Attachment 4

State of Montana
Office of The Governor
Helena 59601

THOMAS L. JUDGE
GOVERNOR

MEMORANDUM *July 31, 1973*

To: All State Agencies

From: Thomas L. Judge, Governor

Re: Multi-County Districting

On August 24, 1971, my predecessor, Governor Anderson, created twelve multi-county districts in order to enhance state agency administration and state planning coordination. Implementation of that order has, in some instances, been delayed due to district and Supreme Court action on challenges to the districting system. On March 28, 1973, the Supreme Court upheld Executive Order 2-71 and removed all legal barriers to its full implementation. A review and evaluation of the multi-county districting system conducted last fall indicated no substantive difficulties among those agencies which had proceeded to implement the uniform districting system. It was found that the activities of some state agencies were more appropriately conducted within groupings of districts rather than on a single district basis. A particular pattern of district groupings occurred most frequently and is shown on the enclosed map.

Based on the above court rulings and evaluation, I am proceeding to fully implement the multi-county districting system created in Executive Order 2-71. In addition, I am directing those agencies that can most productively serve the state with fewer than twelve districts to adopt five administrative regions composed as follows:

Region I - Districts 1, 2, and 3
Region II - Districts 4 and 5
Region III - Districts 6 and 7
Region IV - Districts 8, 9 and 12
Region V - Districts 10 and 11

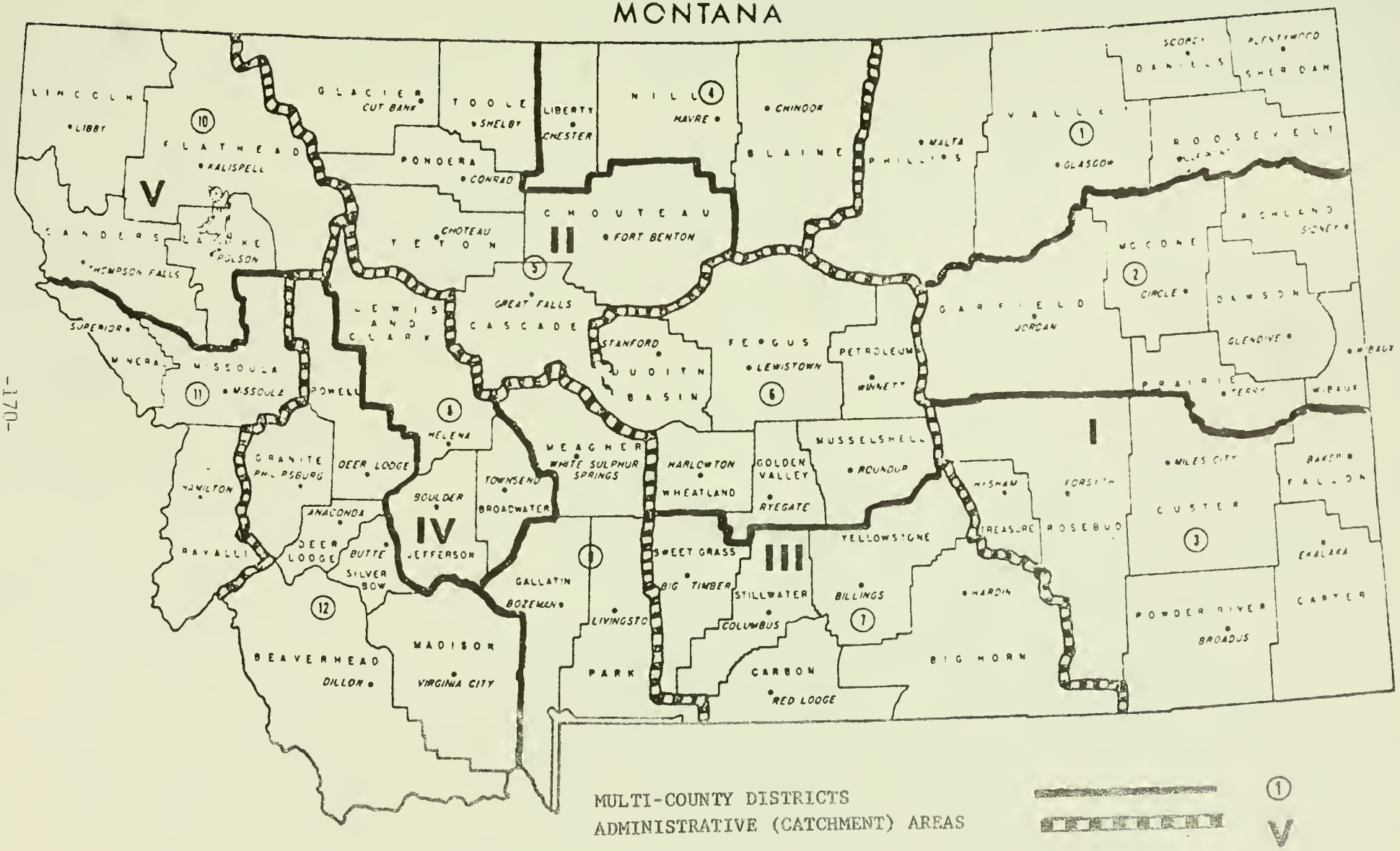
One of the objectives of Executive Order 2-71 was to facilitate planning and program coordination, administration, and delivery

of services by all levels of government within the State." In order to involve local governments as full partners in the district decision-making process, the Department of Intergovernmental Relations has developed guidelines for local governments to follow in establishing district councils. These councils will provide a vehicle for state agencies to communicate with local government. More important, these district councils will develop statements of district policy that will assist in the development of state agency plans and programs. The Department of Intergovernmental Relations will be assisting local governments in the formation of district councils and will be responsible for state recognition of qualified Councils. Information on the relationship between state agencies and district councils and the roles of each will be forthcoming in the near future.

I am asking each department to describe its present districting or arrangements and plans for compliance with the designated districts on the attached form. These should be returned to Dorothy Eck, State-Local Coordinator, Department of Intergovernmental Relations.

Enclosures (2)

MONTANA



MULTI-COUNTY DISTRICTS

ADMINISTRATIVE (CATCHMENT) AREAS

1

V

JUN 26 1979

Attachment 5

State of Montana

GARY R. MARBUT, CHAIRMAN
8000 DARK HORSE ROAD
MISSOULA 59801

STAFF OFFICE:
1218 E. 6TH AVE.
HELENA 59601

Office of the Governor

Mental Health Advisory Council

Helena 59601

June 26, 1979

TO WHOM IT MAY CONCERN:

The purpose of this letter is to confirm the fact that the Governor's Mental Health Advisory Council assisted the Mental Health & Residential Services Division staff with the development of the 1980 State Plan for Mental Health Services.

The Council is pleased to observe that the draft of the 1980 State Plan is an improvement over drafts presented to the council in 1979 and in earlier years, but we feel still more improvements could be made. We hope that this process of improvement will continue into future years.

Council members are grateful for the opportunity of participating in this manner.

Sincerely,

Gary R. Marbut
Chairman

GRM/br

cc: Members, Mental Health Advisory Council